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THE ALBERTA COMMUNITY HEALTH SELF-STUDY OUTLINE: A COMMUNITY DEVELOPMENT APPROACH TO HEALTH CARE PLANNING

by

© PIETER DEGROOT

SUBMITTED TO THE FACULTY OF GRADUATE STUDIES
AND RESEARCH IN PARTIAL FULFILMENT OF THE
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IN

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DIVISION OF COMMUNITY DEVELOPMENT

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THE UNIVERSITY OF ALBERTA

FACULTY OF GRADUATE STUDIES AND RESEARCH

The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research, for acceptance, a thesis entitled "The Alberta Community Health Self-Study Outline: A Community Development Approach to Health Care Planning" submitted by Pieter DeGroot in partial fulfilment of the requirements for the degree of Master of Arts.

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Date 29 April 1977

ABSTRACT

The general study area of this thesis was that of community self-study. The thesis focused on the general problem of doing community self-study, and on the specific problem of community health self-study by the Joint Planning Committees (JPCs) of the hospital districts in Alberta. The JPCs have been given a mandate (that of studying the health needs and resources of their hospital districts), but lack the tools required to accomplish this task. The solution offered by the thesis was the design of a community health study guide (the Alberta Community Health Self-Study Guide, or ACHSSO) which will enable the JPCs to carry out their mandate.

The ACHSSO was designed to facilitate community health self-study and rational health care planning, as well as community development. The latter objective required application of an interdisciplinary approach to health care planning, and a study of various writings on planned change, change agent functioning, strategies for planned change, action research, community action, community self-study, community health self-study, health care planning and community development.

The thesis examined the limitations and assets of two community health study guides: The American Public Health Association's, "A Self-Study Guide for Community Health Action-Planning" (1967) and Hochstrasser's "Community Health Study Outline" (1967). It was argued that neither guide was by itself adequate to serve as a community health self-study guide in Alberta. The design activities of the ACHSSO were discussed and it was suggested that the ACHSSO's usefulness was not

confined to health professionals. Other professionals, organizations and community planning bodies will also find Part I of the ACHSSO (which provides a "how to" guide for community study) useful.

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Lastly, I owe a special thanks to the American Public Health Association who permitted me to borrow freely from their excellent "A Self-Study Guide for Community Health Action-Planning".

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CHAPTER I

INTRODUCTION

A. The Problem

This thesis is concerned with the subject area of community self-study/self-survey,* and aims to make a contribution to the study of various aspects of a community's structure and its health and social needs conducted by change agents. The specific aim of the thesis is to facilitate a better understanding by health and allied professionals, as well as by other community members, of facets of the community which relate to the health and social needs of the community. It is an assumption of this thesis that such knowledge is, in turn, related to the community's ability to improve the quality of life.

The concept of change agent applies to individuals, organizations and communities (Lippitt et al., 1958). In this thesis, health and allied professionals are viewed as change agents (at least they have the potential to be change agents) since they are often in the position of making or recommending decisions aimed at bringing about planned change. It should be noted that there is a fourth type of potential change agent, one which is largely ignored in the literature concerned with planned change; namely, the printed word. Its importance may be inferred from the following statement:

---

*These terms will be used interchangeably in this thesis since the only difference between the two is the mode of enquiry used. Community self-study refers to those activities performed by members of the community whose purpose is to increase an understanding of the community and to bring about planned change.

> The underlying strategy of every change agent should be the improvement of his client's ability to seek information, to define alternatives, to evaluate these alternatives, and to take action to adopt or reject new ideas. In the process of escalating the rate of innovation adoption, change agents sometimes neglect the development of their clients' evaluative capacities. Self-reliance and self-renewing behaviors should be the goals of any strategy for planned change....
> (Rogers, 1972: 207)

The underlying strategy referred to by Rogers is sometimes more economically achieved by the printed word. When written communication is instrumental in accomplishing the underlying strategy, it is the printed word which deserves the designation of change agent.

Change agents working in the fields of health, recreation and social welfare providing a social service or facilitating community action programs, often find it difficult to obtain comprehensive knowledge of their community. More specifically, they are unable to determine what the health and social needs of the community are, and what is being done, and by whom, to meet these needs. Many change agents lack a full understanding of the structure of the community and find it difficult to gather pertinent demographic data (particularly socio-economic information) pertaining to the community of their concern. When change agents have difficulty assessing their community's needs, they are handicapped in performing the change agent function of "problem diagnosis" (Rogers, 1972). This, in turn, detracts from the change agent's ability to bring about change.

My interest in this issue stems from experiencing similar difficulties several years ago when, as part of my field placement work for the M.A. Program in Community Development, University of Alberta, I embarked on an assessment of the community resources pertaining to mental health in the Town of Vegreville, Alberta. My exposure to community development theory and practice, and to community mental health literature, had provided me with some ideas about how I might accomplish this task. However, I soon learned that I lacked adequate "how to" knowledge which would enable me to assess the structure of the community, to determine its health and major social needs, and to identify community resources and gaps in the provision of services in a systematic and comprehensive manner. After one year of Community Development graduate studies, I was still ill-prepared to perform one of the first tasks a community development worker must apply himself to; namely, the assessment of community needs. Second, what I lacked was an organizing "framework" into which my findings about the community could be fit.

I thus learned experientially the value of Brokensha and Hodge's comment:

> It is more important for the community-development worker to be equipped with a framework into which he can fit his observations, and which will help him analyze the communities, than to be in possession merely of hundreds of unrelated facts about social life.
> (1969: 11-12)

During my field placement, I learned that I was not the only one handicapped by a lack of knowledge about systematic and comprehensive community study. One community group in particular shared my handicap - the Joint Planning Committee (JPC) of the hospital district in which I was working.

In 1973, the Alberta Hospital Services Commission (A.H.S.C.)

recommended to each hospital district in Alberta that it establish a Joint Planning Committee. This recommendation was contained in a paper entitled "The Joint Planning Committee: Terms of Reference, Structure, Aims, Objectives" which defined a JPC as follows:

> "...a composite of representatives of the community at large, of all the various health care providing institutions in and adjacent to the community, and of the hospital board and its administrative, medical, nursing and support staffs."
> (1973: 3)

The orientation toward health care planning outlined in this paper is difficult to distinguish from the community development orientation toward the achievement of social change. The A.H.S.C. implicitly endorses in the paper one of the basic goals of community development, a goal which Warren (1973) refers to as the strengthening of the horizontal pattern of the community. The A.H.S.C. suggests that each JPC in the province should conduct a study of the health needs of its hospital district. To encourage this task, the paper provides some limited guidelines for the JPCs to follow.

The specific problem to be addressed in this thesis is the following. While the JPCs have been given a clear mandate regarding their objectives, they have not been provided with a tool enabling them to accomplish this task. The mandate states that the JPCs are to assist their hospital boards in the planning, evaluation and implementation of both short and long-range programs. The guidelines provided by the A.H.S.C. suggest that each JPC should: understand the particular characteristics of its community; define the mission of its hospitals; identify and evaluate existing health care programs; engage in planning for alternative or additional health care programs; and determine what steps might be taken to facilitate integration and coordination of services.

The existence of JPCs are of interest because they provide an institutionalized avenue for citizen participation in the planning of, and provision for, health care delivery, and because they have the potential for stimulating community action and community development activities. It is doubtful that the A.H.S.C., by recommending the formation of JPCs, was aware that it was encouraging the use of one approach to community development; that is, community self-study. However, any JPC which undertakes the task suggested by the A.H.S.C. provides its members with an opportunity to substantially increase their knowledge of their community, and that, in the process of the community self-study there lies the potential for considerable self-growth, leadership development and attitudinal change.

It is my understanding that few JPCs have begun or completed a health self-survey of their hospital district. Work experience and the various enquiries I have made have led me to surmise that this finding is partly due to the fact that members of JPCs do not know how to go about the task of doing the necessary survey. In fact, the need for, and difficulty of, doing a community health assessment has long been recognized, and has been aptly expressed by Freeman:

> Most community health leaders would agree that there is no need more pressing than the one for research that is both intensive and extensive into the nature of, and the methodology for, the assessment of community health that will provide not only a guide for action but also a much needed base for the evaluation of health care.
> (Emphasis not in original, 1970: 254)

It is virtually impossible for any one person or agency to accomplish a total community assessment independent of others. The simplicity or complexity of a community health assessment depends on the situation, and on the preparation and availability of a number of professional workers. Ideally, as has been noted by Boyle (1973: 175), a community health assessment should be a multidisciplinary effort. Unfortunately, this is not always possible or practical.

On the basis of the problems outlined above, it would seem that a community self-study outline adapted specifically to the Alberta health care situation would be of considerable value to JPCs, as well as to others interested in gaining a better understanding of their community. As was noted earlier, one of the objectives of this thesis is to contribute to change agents' understanding of their communities. To this end, the thesis will focus on the design of a community health self-study guide entitled the "Alberta Community Self-Study Outline" (ACHSSO). The development of the ACHSSO is an outgrowth of the following factors: an adaptation of several community health self-study guides developed in the United States; a critical examination of the literature pertaining to planned change, community development and community self-study; personal experience working as a community development worker and as a consultant to community development workers; participation in a resource capacity in two community self-surveys in Alberta; participation as a co-resource person in two workshops on community self-survey; and the encouragement provided by a consultant of the A.H.S.C.

The road to achieving solutions to individual, organizational or community problems, whether whole or partial, invariably requires the exploration of a number of related factors. This assertion applies to the design of the ACHSSO. Had my intention been only to design a health care planning tool, the task would have been simplified, requiring, in the main, the application of knowledge from the field of health services administration. However, since my goal was to design an instrument having a community development facilitating function, as well as being an instrument facilitating health care planning, the development of the ACHSSO required the application of an interdisciplinary approach.

The interdisciplinary approach utilized entailed the examination of the following list of study areas:

1) the nature of planned change;
2) the roles and functions of change agencies and change agents;
3) the nature of the modern community and, particularly, its intra- and extra-community relationships;
4) the problems faced by change agents when studying the structure and dynamics of their community;
5) the question of who engages in community development work;
6) the nature of local autonomy
7) the community's ability to make decisions and solve problems (with particular focus on the mechanisms to be employed for strengthening these abilities).

The discussion of problems associated with conducting community studies highlights the importance of knowing how to study a community. The significance of this issue will be discussed from the vantage point of personal work experience and from observations made by other writers regarding the role of the community study as an "allocative instrument" (Vintner and Tropman, 1970).

Most, if not all, community organizations and government agencies exist for the purpose of providing a service to the community. The types of service provided by organizations and agencies may vary considerably, as does their target population. Certain elements, however, are common to them all. First, financial, personnel or material resources are required in order for agencies and organizations to provide a service or to be of service. Second, the quest for obtaining these resources often entails competition for the allocation of scarce resources. It is with this in mind that Vintner and Tropman state that community studies may be seen as "one means for decision making about the allocation of scarce resources" (emphasis in original, 1970: 316). Third, resource-providing sources have more or less specific guidelines for the allocation of resources.

In some instances, the allocation sources reside in the community (e.g. the United Fund), but more often they are located beyond the community level (e.g. provincial and Federal governments; national charity organizations). Since the demand for resources usually exceeds the supply, it is necessary for priorities to be set by the sources' decision-makers. To facilitate the decision-making process, allocation sources often require that the resource seekers formally document their need and, in some cases, their community support.

In Alberta, the need for documentation applies to a number of fields, including recreation, health care, non-statutory social services and municipal planning. In particular, documentation is required when resources are requested for new services and programs, as is illustrated in the following three examples:

1) Implementation of Comprehensive Home Care Programs (CHCP): These programs will be implemented throughout the Province over a period of at least five years. The implementation process requires that communities make their requests for funding to the Government of Alberta through their local health units. Requests must be accompanied by extensive documentation of the community's structure and health needs.

2) Recreational Master Plan Funding:
To become eligible for funding for recreation facilities and other recreational resources from the Department of

Parks, Recreation and Wildlife, a community or region must submit a comprehensive documentation of their recreational needs and must demonstrate long-term planning.

3) Preventive Social Services Cost-Sharing:
Municipalities may approach the Government of Alberta for cost-sharing of preventive social service projects aimed at meeting social needs. Allocation of funds will be considered only when a need is documented.

Communities having local change agents who are able to assess their community and its needs, and who can provide valid documentation substantiating need and community support, often have a decided advantage in obtaining new, or expanding existing, resources. Such communities are usually the cities and larger towns. In the three examples stated above, the work involved in preparing documentation to substantiate need requires some type of community study. To accomplish this task, professionals and lay members of the community collaborate in the community study effort. Vintner and Tropman classify studies undertaken by communities as requirements for funding as "planning studies" (1970: 321).

In addition to the need for funding, Vintner and Tropman (1970: 315) outline a number of other problems and concerns which give rise to community studies. Some examples are the following: recognition of community needs; uncertainty about service effectiveness; deficiencies in the distribution of services; and concern regarding the coordination and integration of health and social services. The authors argue that the various problems relate to decision-making about "who gets what, when and how" (1970: 315) and derive from the following factors: 1) the fluctuating state of our society; 2) shifts in political values and changes in community needs; 3) changes in population characteristics; 4) technological development; 5) the trend toward increased interdependence within local communities, and between communities and other sectors of society (1970: 316-317).

Personal observations lend support to the conclusion reached by Blum (1974) and Vintner and Tropman (1970): that is, that community studies (particularly community self-studies) have an impact on existing policies and service delivery. In part, this is due to the fact that community self-study activities involve individuals who are outside the resource control structure and, as a result, contribute new viewpoints and insights. Due to their input in the study activities, new and more pressing needs are often identified, new power configurations may develop, and new involvements may be generated.

An important aspect of the community study is that it provides a context for "a deliberate and orderly, if not entirely impartial, review of service requirements and patterns" (Vintner and Tropman, 1970: 320). The context provided by a community self-study is one in which different points of view can be explored, and one in which new interests may emerge. The latter is especially important when there is strong resistance to planned change within the power structure.

In summary, the community self-study may have the following effects: it may have a decisive influence on whether or not resources are allocated; it may serve as a vehicle for allowing needs to be identified and new interests to emerge; it may increase the existing power structure's awareness that "things have changed", and that new approaches to existing needs may be required; and it may change and increase local decision-making processes (a point to be discussed in Chapter II). What Poplin writes about a well-conceived community program applies equally to the activities and processes involved in community self-study; namely, that it encourages "people to mobilize whatever resources they have in an effort to improve conditions at the local level" (1972: 238).

B. Research Procedures

1. Field Research

The preliminary field research for this study was conducted during the summer of 1974 in the Town of Vegreville, Alberta. The research was a pilot project undertaken as part of my field placement for the Program in Community Development at the University of Alberta. Originally, the aim of the project was to assess the resources pertaining to mental health. However, the focus was eventually expanded to include other aspects of community health and was guided by a community health study outline prepared by Hochstrasser (1967) which will be referred to as the Kentucky Health Study Outline.

The field placement research familiarized me with some of the problems confronting individuals and groups who lack the expertise to conduct a community self-study. Of particular concern were the problems associated with gathering certain current demographic data, and with "fact finding" about the health and social services delivery system in Alberta (i.e. attempting to learn which professionals working for the various government departments are providing which particular services).

In 1973 and 1974, I participated as a co-resource person in two workshops on the topic of community self-survey/self-study, conducted by the Faculty of Extension, University of Alberta. These workshops provided a sounding board for learning about professional interest in the methods of community self-study, and for learning about the problems which confront change agents in their attempts to gain a better understanding of their community. Further, involvement as a community self-survey consultant to two Alberta communities (Edson and Stettler) provided an opportunity to apply the knowledge gained from my studies and the workshops, as well as acquainting me with some of the community dynamics that occur when a community studies itself.

2. Library Research

The literature review included readings for university courses in community mental health, urban community study, and community development. The writings of Sower et al. (1957), Selltiz and Wormser, (1949), Lippitt, et al. (1958), McClusky (1973), Warren (1973) and the reports of the National Commission on Community Health Services (United States) served as the most stimulating and helpful sources for the present study. The writings of Rosenthal (1972), Mico (1965), Wolf (1964), and Kimball (1952) present a number of weaknesses and problems involved in the community self-study method.

3. Designing the ACHSSO[*]

The task of designing the Alberta Community Health Self-Study Outline began by comparing the Kentucky Health Study Guide and the American Public Health Association's Health Self-Study Guide and noting their strengths and weaknesses.[**] Chapters in public health nursing and health services administration texts dealing with community health and health services assessment were also examined for relevant content. Some format features of the two guides were borrowed and placed in new combinations.[*] In addition, content material was borrowed when applicable to the Alberta context, although much of the content was revised to take into account different health-related terminology and the different health care systems. The sections from the two guides which deal with demographic data were adapted to Statistics Canada and other sources of data. The revisions were checked for accuracy and relevance by knowledgeable individuals in a number of fields.

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[*] Details of the design process are contained in Chapter III.

[**] D.L. Hochstrasser and Staff of the Department of Community Medicine, Community Health Study Outline, University of Kentucky, 1967 (unpublished manuscript); American Public Health Association, A Self-Study Guide for Community Health Action-Planning, (two volumes), New York, New York: 1967.

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[*] Copyright permission has been obtained from the relevant sources.

CHAPTER II

A CRITICAL REVIEW OF THE LITERATURE

Since the goal of the thesis is to contribute to the ability of health and allied professionals and other change agents to bring about planned change, it will be fruitful to discuss the viewpoints of a number of writers regarding the functioning of change agents, the assumptions change agents make about their client systems, the types of communication models used, as well as the skills and strategies for action. The discussion will be limited to a review of the relevant writings of Lippitt, Watson and Westley (1958), Rogers (1972), Kimball and Pearsall (1954), Warren (1973) and Blum (1974).

After an examination of the writings about planned change and change agent functioning, this chapter will focus on various writings concerned with the following: community study (Vintner and Tropman, 1970; Poplin, 1972; Mico, 1965); community action and community self-study (Sutton and Kojala, 1960; McClusky, 1973; Verner, 1971; Poplin, 1972; Mico, 1965); and the "why, who, what, where and how" of community self-study (Goulet, 1971; Schindler-Rainman and Lippitt, 1972; Anderson and Burke, 1959; McClusky, 1973; Stinson, 1971; Rosenthal, 1972; Conant, 1968; Sower et al., 1957). The chapter will close with a discussion of the degree of "fit" of community self-study with two of Rothman's three models of community organization; namely, the locality development and social planning models (Rothman, 1972).

A. Change Agents and Planned Change

The work of Lippitt et al. (1958) has been singled out for discussion for several reasons. First, their analysis of change agent functioning is based on a systems approach to planned change. Second, their writing focuses on the community self-survey method as one communication model by means of which change agents, working with communities, impart knowledge and skills for problem-solving to their client system. Third, they discuss in depth the change agent's role, and the various phases of the process of planned change.

In their comparative study of the functioning of change agents, Lippitt et al. examine the change agent's functioning by considering four types of client systems: the personality, the group, the organization, and the community system. By analyzing the functioning of the change agent in relation to the particular type of client system, similarities, differences and problems in functioning are highlighted. Lippitt et al. hold that there are certain problems within each of the four systems which are dealt with by professional helpers. All helpers, regardless of which system they work with, are regarded as change agents, their purpose being to increase the client's ability, skills and techniques of problem-solving in two areas: the client's "internal processes", and the client's relation to his external environment. The change agent's role is seen to be that of a resource and catalyst. The methods used for improving the client's problem-solving ability depend on the client system which is involved.

In order to help the client **system** deal more effectively with problems related to its internal processes, change agents make certain assumptions about the client system, three of which will be outlined below.

The first common assumption which change agents make about a community is that its internal distribution of power is "faulty". If the assumption is found to be true (that is, that the community has a problem of a "faulty" power distribution), the change agent will attempt to assist the community in developing a more appropriate power structure. Different approaches may be used to redress a faulty distribution of power.* Lippitt et al. state:

> ... the change agent, acting in his proper role, may be concerned about developing new centres of power or about making old ones more representative of the client system as a whole. His approach is generally to look for new sources of leadership or strength within the client system ... and to help locate the problems and action strategies by which these new combinations of strengths can assume the habits and confidence of authority.
> (1958: 31)

As related to this thesis, the establishment of JPCs in Alberta may be considered as one approach to changing the internal distribution of power in the area of hospital and health care planning.

A second common assumption is that communities have problems regarding the "internal mobilization of energy". A great deal of community development work is oriented toward mobilizing and channelling used and unused resources within a community. Where apathy characterizes the community, the community development worker aims to encourage members of the community to assume responsibility for community problem-solving. In part, the design of the ACHSSO is based on the following assumption:

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*See Alinsky, 1969; Poston, 1953; and Thelen, 1951.

> ... ways can be found to relate subparts of a system more effectively to the whole and that when this has been done the energies and ideas originating in the subparts will become more fully available to the whole client system. (Lippitt et al., 1958: 38)

Collaboration between members of the community and health and allied professionals in a community health self-study effort is an example of using available energies with better effect.

A third assumption is that the community's "internal communication" frequently creates barriers to planned change. In order to improve existing patterns of communication, community self-surveys are often used as a method of community development and as a means to increasing communication between various sectors of the community. Selltiz and Wormser (1949) demonstrated the use of community self-survey as a means of reducing ethnic discrimination problems. In the context of this thesis, it is suggested that the JPC could be considered to be one mechanism for improving internal communication within a particular sphere of community concern.

In addition to making assumptions about the client system's internal processes, the change agent focuses on various aspects of the client system's external relationships. One of the change agent's major objectives is to alter the relationship between the client and its environment. One strategy for accomplishing this task is to strengthen the client system's ability to engage in effective action. One important means of doing so is by helping the client system to improve its problem-solving skills. I share with Lippitt et al. (1958: 63) the belief that change agents should serve as resources and catalysts for the client, particularly as related to problem-solving. In like manner, the AHSSO aims to fulfil the function of increasing skills and strategies for action. Further, it attempts to facilitate changes in the goals and values of JPC members and of professionals delivering health services.* Not only is the ACHSSO conceived as a change agent; it is also meant to be a tool which enables JPC members to be their own change agents.

One writer who elaborated upon the writings of Lippitt et al. is Rogers (1972). Rogers focuses on change agent roles and strategies for fostering planned change and he clearly illustrates that, in the process of planned change, there are several which can be identified. Linked to these functions are two main themes developed by Rogers: that, 1) the change-agent-client relationship is characterized by reciprocity, and 2) that the chance of maximum effectiveness is increased if the change agent utilizes a "strategy of change". Before examining the various change agent functions it will be useful to focus on Rogers' discussion regarding change agents and the nature of planned change.

Rogers defines a change agent as "a professional who influences innovative decisions in a direction deemed desirable by a change agency" (Emphasis in original, 1972: 194). Rogers' detailed examination of the concept arrives at the following conclusions: change agents seek to influence their clients' behavior; change agents attempt to facilitate client decisions to adopt or (though less often) reject innovations;

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*Lippitt et al. (1958: 63) discuss the impact of change efforts on client values and attitudes.

and change agents should take into account the clients' needs if the change agent-client relationship is to be maintained. The latter point suggests that when the clients' needs are taken into consideration by the change agent there is not only a reciprocal relationship, but also a greater chance that the change objectives will be achieved. Consideration of client needs is one of the basic principles underlying the community development approach to planned change.

In writing about a "change agency", Rogers asserts that change agents are "employees of formal organizations, such as government ministries or commercial companies" (1972: 195). Following from this, one could argue that the Alberta Hospital Services Commission is a change agency which aims to bring about planned change. However, it is difficult to determine whether the A.H.S.C.'s suggestion that hospital boards in the Province should establish JPCs represents consideration of client needs (rather, consideration of client "felt" needs). In order to determine this, it would be necessary to gauge the perceptions of the members of the various hospital boards in Alberta regarding the need to establish community health study groups such as JPCs.

As was noted earlier, I consider the ACHSSO to be a change agent. This viewpoint has been reinforced by Rogers' discussion of seven change agent functions that can be identified in the process of planned change. These functions are: developing a need for change; establishing a change relationship; problem diagnosis; examining goals and alternative courses of action, and creating in the client a desire to change; influencing the client so that the desire to change becomes translated into action (and so that the client innovates); stabilizing the change by reinforcing the client to continue to use the innovation;

and, achieving a terminal relationship.*

It is important to note that planned change can occur without the existence of all seven change agent functions. For example, during the outbreak of an epidemic, planned change may be introduced by coercive measures by the introduction of compulsory immunization programs for the population at risk. However, in such situations, social planning, rather than the community development approach to achieving planned change may be said to be operating.

What follows is an attempt to assess the ACHSSO according to the seven change agent functions outlined by Rogers. First, the ACHSSO aims to develop a need for change in that its basic orientation is to stimulate the JPCs to examine the need for planned change. Second, does the ACHSSO establish a change relationship? Rogers writes that "a change agent must foster a belief among his client that he is competent, trustworthy, and empathetic with his clients' position" (1972: 196). At present, it would be difficult to argue convincingly that Rogers' ideas about these change agent qualities would be met by the content of the ACHSSO. However, to date, feedback provided by knowledgeable health and allied professionals regarding the content of the ACHSSO suggests that it will be considered competent, trustworthy and empathetic with its users' position.

Third, one of the basic aims of the ACHSSO is to facilitate the diagnosis of problems. However, one difference between the ACHSSO and professional change agents must be noted. Rogers states that change agents are responsible for diagnosing their clients' problems from the clients' perspective. Obviously, the ACHSSO itself cannot fulfil the function of actually diagnosing problems. It can only facilitate such diagnosis. The same applies to the examination of goals and alternative courses of action, Rogers' fourth function. But the ACHSSO does aim to create in the client "the intent to change" (Rogers, 1972: 196) and it encourages the JPC to take action, such as recommending to its hospital board that certain actions should be taken (fifth function). The ACHSSO itself can do little to stabilize change or reinforce clients who have adopted innovations (sixth function). The function which the ACHSSO accomplishes best is that of achieving a terminal relationship with the client, a function about which Rogers writes:

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*While Rogers does not point this out, these seven change agent functions may also be considered as seven phases of the chain of events in the change process.

> The goal for any change agent is to develop self-renewing behavior on the part of his clients. The change agent should seek to put himself "out of business" by enabling his clients to be their own change agents.
> (Emphasis in original, 1972: 197)

The discussion will now focus on the two major themes referred to earlier: reciprocity of the change agent-client relationship and the change agent strategy. Rogers suggests that the nature of a change agent-client relationship encompasses several variables which, while they may be seen as separate concepts, should be considered as a "series of interacting dimensions" (Rogers, 1972: 201). They are reciprocity, homophily, empathy, and credibility. In the following, each dimension will be discussed in relation to the ACHSSO.

Reciprocity would be applicable to the ACHSSO if the ACHSSO was to be updated so that the feedback provided by its users was taken into consideration. The concept of homophily* is important to the practice of successful community development work as it suggests that communication effectiveness is increased as the degree of homophily increases. This concept is related to the ACHSSO in that, in order to be effective in stimulating planning for change, the ACHSSO's language and content must be seen to contain meanings and interests held in common by its users. It could be argued that the homphily concept provides a rationale for adapting health study outlines designed and used in the United States to Alberta conditions. However, a composite health study guide, based on the Kentucky Health Study Guide and the A.P.H.A. Health Study Guide (i.e. with no changes in terminology, etc.) would not have been optimally useful in Alberta because the "heterophily gap"** would have been too great.

The concept of credibility was very important to the design of the ACHSSO. In order to ensure maximum credibility, verification of the content of various sections of the ACHSSO with knowledgeable health and allied professionals who had first-hand practical experience in particular health subject areas was necessary. Whether the ACHSSO will indeed have credibility will only be determined when the instrument is used by JPCs or other user groups.

In the foregoing discussion of Rogers' views on change agents, clients, and planned change, a discussion of the concept of strategy and its relationship to the various change agent functions was omitted, except to note that the utilization of a strategy enhances planned change efforts. But not all strategies will have an enhancing effect. Therefore, it is expedient to follow some strategy guidelines which have been derived from research concerning effective programs of change.

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*Rogers notes that "Homophily is the degree to which pairs of individuals who interact are similar in certain attributes ... greater reciprocity is involved when the change agent and client are more similar to each other" (1972: 202).

**The heterophily gap refers to the degree to which shared common meanings and interests, and perceived attributes, are lacking.

These strategies are important to follow when conducting a community self-study. Rogers (1972: 206-207) identifies four factors which are related to these guidelines: cultural fit, client participation, use of opinion leaders, and the clients' evaluation ability. It should be noted that it is possible to discern the operation of these four factors in the A.H.S.C.'s description of the role of the JPCs in Alberta. Rogers states that programs of planned change will be "more successful if they are relatively compatible with the existing cultural beliefs, attitudes, and values of the client" (1972: 206). A good illustration of this statement about the importance of "cultural fit" is provided by Sower et al. (1957) in their description and analysis of the community health self-survey carried out in Independence County.*

Presently, there are many communities in Alberta where professional and lay members of the community are working together, surveying particular community needs and planning for services and facilities. Planning groups (other than hospital boards) which come to mind are recreation boards, Preventive Social Service boards, local boards of health, social planning councils, and community resource center boards. These planning groups generally involve their targets (clients) in the planning process, and thus increase the likelihood of success. The formation and functioning of the JPC is an excellent example of an attempt to ensure that the unique needs of the clients are taken into consideration when planning for change. Also, the JPC helps to increase community commitment to implementing recommendations and provides legitimation to innovation decisions resulting from the JPCs study and planning efforts.

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*A fictitious name for a county in the American Midwest.

Improving the clients' evaluation ability is one fundamental strategy guideline underlying the community self-study approach to community development. I am not aware of any other approach to community development in which there is as strong an emphasis on improving the community's "ability to seek information, to define alternatives, and to take action to adopt or reject new ideas" (Rogers, 1972: 207). While professional change agents often aim to encourage self-reliance and self-renewing behavior--ideal goals of community development--they often find it difficult to do so, as any Preventive Social Service Director in Alberta will be able to corroborate. When the change agent is an instrument such as the ACHSSO, the chance of creating dependency is minimized.

Finally, the relationship between community health self-study and the use of opinion leaders will be discussed. Rogers (1972: 207) observes that change agents' time and energy are always scarce resources and that planned change is often more effectively achieved when the change agent enlists opinion leaders. Not only does such utilization entail an economy of change agent effort, but active involvement of opinion leaders serves to provide sponsorship and legitimation for the proposed innovations that comprise planned change. The formation of JPCs capitalizes on the idea of involving opinion leaders in planned change activities since the A.H.S.C. has suggested that the JPCs should be composed of health and allied professionals and other influentials in the community.*

Strengthening the self-development and self-reliance abilities of the community has been of concern to several writers (Rosenthal, 1972; Kimball and Pearsall, 1954) who worked with groups conducting community self-studies. Kimball and Pearsall (1954) focus on two issues: who should direct the processes of change, and how the community's ability to manage change can be strengthened. In particular, the authors deal with the issue of control over the social environment and they question who should exercise this control - the elite or the general public?

> The question presents itself whether these controls should be vested in an elite which directs the destiny of human society, presumably for its own salvation, or whether the knowledge and direction should be redistributed throughout the body politic.
> (1954: XXII)

Kimball and Pearsall favor the general public having control. They stress that communities can increase the amount of control they exert over planned change.

The need for strengthening the community's coping or self-reliance abilities has been stressed by Warren (1973). Warren analyses the nature of the modern community, focusing on the influence which extra-community ties exert on the functioning of change agents. Two important concepts (horizontal and vertical interaction patterns) put forth by Warren bear a strong resemblance to Lippitt et al's concepts of internal processes and external relationships discussed earlier. As was noted, Lippitt et al. suggest that change agents might find it useful to delineate between problems which fall within the domain of internal processes (or internal relationships) and external relationships. Thus, the concepts of internal processes and external relationships were intended to serve as boundary markers for problem delineation. Warren's concepts of the horizontal and vertical pattern are intended to characterize two types of community interaction. The horizontal pattern refers to interaction between units within the community system (what Lippitt et al. term the "internal processes"), and the vertical pattern refers to interaction between units of the community system and units of systems that are external to the community (what Lippitt et al. call "external relationships").

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*See "The Joint Planning Committee: Terms of Reference, Structure, Aims, Objectives" prepared by the Alberta Hospital Services Commission, 1973.

Like Lippitt et al's analysis of change agent functioning, Warren's conceptualization of the patterns of community interaction is based on the system approach to community study. Further, his concepts represent a development of earlier concepts of community interaction.*

The community's vertical pattern refers to the structural and functional relationships of its various social units and subsystems to _extracommunity_ systems. The vertical pattern of community interaction is characterized by a hierarchical relationship in which the extracommunity system has a higher level of authority, administration, decision-making, etc. than the community's subsystems.*

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*These concepts include task and maintenance functions, Redfield's folk and urban component of community living, and Homan's external and internal systems. See Warren (1973, Chapters 8 and 9).

The community's horizontal pattern refers to the structural and functional relationships of its various social units and subsystems to _each_ _other_. The term "horizontal" is used to indicate the following:

> ... the community units, _insofar as they have relevance to the community system_, tend to be on approximately the same hierarchical level (a community unit level, as opposed to a state, regional, national, or international level of authority, administration, decision-making, and so on). (Emphasis in original, Warren, 1973: 162)

The operation of the horizontal pattern is therefore evident when there is interaction between local units or subsystems within the health care continuum of locality relevant functions. An undertaking such as community health self-study, which brings together various health and allied professionals (as is the case with the JPC), is an example of the involvement of the horizontal pattern. Further, a body such as the JPC may be viewed as a "new and formal system for integrating the forces of community life" (Kimball and Pearsall, 1954: xv). It is of interest to note that the establishment of the JPCs principally involved the vertical pattern of community interaction, while the actual task of doing a community health self-study involves the horizontal pattern.

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*See Warren (1973: 135-166) for a detailed discussion of the terms social system, structural and functional relations, social units, and subsystem.

Warren believes that the "great change"* (1973: 53) in urbanized societies has weakened the horizontal pattern of community interaction, which, in turn, has had some far-reaching consequences: increased community reliance on extracommunity decision-making and problem-solving; decreased local autonomy and cohesion and a decreased spirit of self-reliance.

This weakened horizontal pattern can be demonstrated by focusing on the extent to which health professionals are influenced by their extracommunity ties (i.e. the vertical pattern), a topic which has been examined by Blum (1974: 519). Blum believes that educational background, professional status, membership in professional associations and exposure to professional journals have resulted in health professionals being guided more by their professional loyalties and commitments than by the community's expectations of their functioning as health professionals. The effect of the vertical pattern on the professional functioning of health agents (and how this effect can be counter-balanced) has been described by Blum as follows:

> The overlap of membership in vertical and horizontal (locally oriented) organizations has the value of sparing most of us from a totally one-sided view. Hopefully, comprehensive planning will benefit from this duality of view. Local planning can clarify horizontal needs

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*Warren's concept of the "great change" aims to denote the significant alterations in community life which have occurred in modern communities. Warren notes aspects of the great change in the following areas: the division of labor, the differentiation of interests and association, the increasing systemic relationship between the community and the larger society; bureaucratization and impersonalization; the transfer of community maintenance functions to profit enterprise and government; urbanization and suburbanization; and changing values (1973: 53-94).

> without overlooking vertically inspired concerns of members of the community; in return, vertically oriented groups can utilize their across-the-country connections and national positions to make various local needs understood.
> (1974: 519)

The above statement illustrates the applicability of Warren's concepts of the vertical and horizontal pattern to a problem situation involving health professionals working as change agents. Taking into consideration Blum's statement regarding membership in vertical and horizontal organizations, it can be argued that, in encouraging the formation of JPCs, the A.H.S.C. was attempting to strengthen the horizontal pattern. Strengthening the horizontal pattern is a major goal of community development, a factor recognized by Warren in the following excerpt:

> ... community development is distinguished by its emphasis on the long run, and its primary attention to strengthening the horizontal pattern. Further, it represents an attempt deliberately to "administer" a program of strengthening the horizontal pattern, rather than leaving it to the operation of the interactional "market".
> (1973: 323)

This section has focused on the topics of planned change and the functioning of change agents in general. The following sections will be concerned with a particular type of community study, the community self-study, and its relationship to community action and community development.

B. Types of Community Study

Community studies have been part of the social research landscape for many decades. They have been undertaken under varying sponsorships, and with varying short and long-term consequences. Varied too are the forces that have given rise to community studies (Vintner and Tropman, 1970). Although this chapter's major focus is the method of community self-study, some other types of community study will be briefly discussed first.

In his review of the community research literature, Poplin (1972) identified three types of community study: race relations, social stratification, and ethnographic research. According to Poplin, the ethnographer studies the community as a totality in order to gain an understanding of its constituent parts (units and subsystems) and their interrelationships. Some community self-studies focus on race relations or social stratification, but more often the concern is broader, so that such research would be classified as ethnographic research.*

Mico (1975) offers the following typology of community studies: agency study, expert study, commission study and community self-study.** The typology is not all-encompassing since it does not include the traditional community study which, according to Kimball, is characterized by:

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*Poplin comments that "the term ethnographic implies that the investigator attempts to describe the community as a totality and to see the manifold and complex interrelationships between its parts" (1972: 258).

**Mico defines an agency study as one conducted within a given organization, where the concern is with "internal mechanizations" or with problems or programs for which the organization exists. An expert study is conducted by an outside consultant or firm for a particular agency. A commission study is carried out by ad hoc groups which are established by governmental decree to produce recommendations for political action. A community self-study involves significant elements of the community, is carried out by local individuals or groups, and is undertaken in a voluntary, cooperative manner with a view to future action for planned change (Mico, 1965: 289).

> ... a definition of problems based on academic considerations... Since the problems are academically oriented there is no guarantee and, in fact, there is little assurance that the findings will have more than the broadest implications for action.
> (1952: 160)

1. The Community Self-Study Method

The community self-study method, while sharing some of the characteristics of the other types of community study, differs from them in certain respects. Before considering the similarities and differences, the relationship between the community self-study method and the concept of community action will be examined.

a. The Community Self-Study Method and Community Action

It has been noted that community self-study is a particular type of community study, possessing certain identifying characteristics. Further, the nature of community self-study will be better understood by examining its relationship to what is called "community action". In order to state what kind of activities may legitimately be considered as constituting community action, it is necessary to determine which activities are communal in nature and how these activities may be distinguished from non-communal activities. Sutton and Kojala (1960) believe that it is impossible to sharply distinguish what is best included in the universe of community action. They suggest that it is more fruitful to study locality-oriented events and activities in terms of their degree of "communityness"* (what McClusky calls a "community oriented" study, 1973).

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*See Sutton and Kojala, 1960.

Communityness includes the following components: 1) the degree to which an event or activity is locality oriented, 2) the degree to which the individuals involved in, or influenced by, an event or activity are identified with the locality, and 3) the extent to which local people participate in an activity (Poplin, 1972: 182).

Verner (1971) notes that planned change can occur on different levels of the community's structure and that each level represents a different degree of involvement in action programs. Levels of potential action in the community which Verner identifies are: the individual, the small group, the sub-organization, the organization, the multi-organization, and the community.

Verner also notes that the terms used to describe social phenomena are often imprecisely identified, and that the same term is frequently applied to several discrete phenomena. Two terms which fall into this category are "community action" and "social action". Verner describes social action as that which is initiated and implemented by a single organization in its attempt to solve a community problem. Community action, on the other hand, is a "process of change conceived and carried out by a community as a discrete social unit" (Verner, 1971: 422). In other words, when individuals representing different segments of the community are involved in a particular action as a group or subsystem of the community, they are acting as a discrete social unit. Verner's differentiation between social and community action is only intended to identify "the position of the action in the structure of the community" (Verner, 1971: 422), and does not imply that one ipso facto has a higher value than the other.

An important difference between social action and community action is that, only in the latter do:

> ... all segments of the community have an equal opportunity to participate in the change program. Not all members of the community may become involved in the action, but all must share the responsibility.
> (Verner, 1971: 421)

In fact, it is doubtful that Verner's reference to "equal opportunity" applies to the modern community since such factors as social status, level of education and ethnic background often mitigate against community members' equal opportunity to participate. Another difference between the two types of action is that community action can only occur on the community level, while social action can occur on any of the five subordinate levels outlined by Verner.

Verner's clarification of the characteristics of community action is helpful for understanding the nature of different kinds of community action, three of which have been defined by Poplin (1972): spontaneous, routinized and planned.* Of the three, the planned or initiated type of community action is of the most interest in this thesis since its traits (as outlined by Poplin) are applicable to the community self-study.

Initiated community action, according to Poplin, is characterized by the following: its main purpose is the initiation of change at the community level through the mechanism of orderly group processes; its emphasis is on solving problems or achieving concrete goals; it involves the voluntary participation of community members, groups or institutions; and it represents a democratic orientation, a factor which should be reflected in minimal control by vested interest groups and an opportunity for participation by all interested citizens.*

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*Spontaneous community action includes such events as riots, student demonstrations, mob actions and civil disorders. Routinized community action encompasses community events or activities which take place on a recurrent basis, such as annual parades, regular fund drives, etc. See Poplin (1972: 184).

It should be noted that the involvement of citizens in community action refers to their involvement as community members rather than as employees of an agency or business organization. In reality, however, it is often difficult to determine of the individual is primarily involved in his/her role as a citizen, since involvement in community action often stems from individuals fulfilling their roles as employees.

In some respects, the crucial identifying feature of initiated community action is that the action is an episodic event in the stream of community life. As Poplin describes it, "a group comes into being, action is taken to bring about a desired change, and the group disbands or undertakes some other project" (1972: 187). Mico conveys a similar viewpoint in his description of community self-study:

> A community self-study is a special action project, designed to promote planned change in the community. It implies a broad base of agency and leadership support to attack and resolve problems so comprehensively in nature that they are beyond the scope of an existing agency, or a given coalition of agencies. It should be an _ad hoc_, or temporary project, culminating with the implementation of the plans. (1965: 290)**

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*This discussion is based on Poplin (1972).

**It should not be inferred from Mico's writing that _all_ community actions or self-studies aim to deal with very severe problems, nor that a "broad base of agency and leadership support" is always required.

One characteristic of community action which is fundamental to the ideal initiated community action is that the maximum number of people "should be involved in setting goals, planning for action, and carrying the project through to completion" (Poplin, 1972: 189). Sometimes, however, this desired condition is difficult to achieve, particularly when the community action takes the form of a community self-survey. The characteristics of initiated community action outlined by Poplin are shared by the community development orientation toward planned change. It is not surprising, then, that Poplin should write that the terms community action and community development mean "essentially the same thing" (1972: 238).

b. Community Self-Study: Approaches and Issues

This section will examine some of the relevant writings on community self-study. Since community self-survey stands as a separate area of community self-study, writings concerned with the former will be referred to only when the content has relevance to community self-study. Recent textbooks concerned with public or community health nursing stress the importance of knowing one's community (e.g. Reinhardt and Quinn, 1973; Tinkham and Voorhies, 1972; and Freeman, 1970). Freeman (1970), for example, considers community assessment or diagnosis to be fundamental to the practice of public health nursing.* While the textbooks focusing on the importance of community assessment encourage individuals to become knowledgeable about the community, they are more appropriately classified as part of the literature of community study rather than of community self-study.

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*The Nurse Practitioners' Program at the University of Alberta's Faculty of Nursing places strong emphasis on community diagnosis.

Community self-study programs share with community development theory an emphasis on citizen participation, problem-solving, "learning by doing", self-help, and the determination of the felt and unfelt needs of the community. All of these factors are evident whenever a group of citizens decides to study some aspect of its community, with a view to bringing about desired change. Whenever such study efforts are undertaken, there is a concern with obtaining information and determining facts; hence, the use of the community self-study.

The community study and community development literature contains numerous accounts of community self-study endeavors, most of which focus on the steps in the study's development and termination. As is the case with other types of community study, community self-study projects are undertaken to achieve various objectives (which initially may not be clearly defined). The self-study may be confined to a few selected aspects of community life, or it may be a comprehensive study of many facets of the community's structure and dynamics. Whatever the scope of the self-study, in order to qualify as a community self-study it must be problem-oriented and deserving of the designation of "action research" (i.e. research which has as one of its specific objectives, to bring about planned change).

Goulet (1971) analyzes in some depth the writings of an early proponent of the community self-study approach. According to Goulet (1971: 161), Caillot devised the method of "participation-survey" in the early 1960's. The method involves a blending of the analytical and conceptual skills of experts, with the knowledge held by the ordinary citizen. Goulet recognizes that the "participation-survey" represents action research, as may be inferred from the following:

> First, this enterprise combines study and action ...An attempt is made to wed the experience of those who experience problems to the analytical skills of those who conceptualize them. The expert's role consists in supplying broad information, posing problems, eliciting critical reflection and accurate observation, and coordinating the work of numerous multi-disciplinary teams. Quite apart from stimulating cooperation between experts and people, the method encourages the collaboration of different sub-groups among the people themselves. Its originality consists of transforming study and discussion groups into action groups.
> (1971: 161-163)

Of central importance to an understanding of community self-study is that it constitutes action research, a notion first developed by Kurt Lewin (1948) and summarized below by Schindler-Rainman and Lippitt:

> Kurt Lewin first articulated the strategy of action research in which he expressed the belief that research could most effectively lead to action if the persons and groups who need to be involved in action taking were involved earlier in the process of diagnostic data collection and analysis. He pointed out that involvement in clarifying the research or diagnostic inquiry and participation in fact-finding had an important psychological impact on helping individuals clarify and objectivy their evaluative and resistive stances against change, and helping them arrive at the commitment to "get their efforts worth" out of their involvement in fact-finding he becomes involved in the carrying-through of the implications of the findings.
> (Emphasis in the original, 1972: 4)

The writings of Schindler-Rainman and Lippitt suggest a number of principles of community development which have been outlined by other authors. The following characteristics of community development which are reflected in Schindler-Rainman and Lippitt have been noted by Dunham (1970: 172-174): involving people in actions that promote their welfare; using local leaders and existing agencies; helping people to recognize their own needs; and using the community approach. The principles of community development outlined by Di Franco (1958) are also in evidence: a concern with bringing about social change in the community; a concern with problem-solving; use of the self-help philosophy, which involves the acceptance of the principle of maximum feasible participation; a concern with both task and process goals; and direct rather than indirect participation.

Many of the accounts of community self-study projects reveal that the projects were either directly or indirectly stimulated by extension activities of university departments, or were made possible because of access to financial or other resources provided by national organizations. For example, in 1962, the United States National Commission on Community Health Services established a national program for supporting community self-studies. A number of writers (Anderson and Burke, 1959; McClusky, 1973; Larsen, 1962; and Stinson, 1971) have revealed that the universities with which they were associated encouraged community self-study projects. Of these writers, McClusky and Rosenthal have made important contributions to the idea of planning for change, particularly the role assumed by information. Their writings form the basis of the following discussion.

In his discussion of the assumptions underlying a particular university's involvement in a community self-survey, Rosenthal (1972) emphasizes the assumption that "knowledge represents power". Rosenthal credits Innes (1964) with having argued convincingly that decision-makers have traditionally been able to maintain the status quo because of their monopoly of knowledge and of the media of communication. Conant's analysis of the politics of community health action studies in five communities focuses on the roles assumed by community leaders in achieving health action results (1968). Conant notes that community self-study is both an educational and a political process, although the latter has been given little attention in the literature.

McClusky (1973) also acknowledges the role of knowledge or information as a source of power, although his major emphasis is on the "educative" use of information in community self-study and on the role of information in community development.* The importance of the role of information in bringing about change is reflected in McClusky's conceptualization of community self-study as the "Information Self-Help Approach" (ISHA).** It is McClusky's view that the educative use of information serves as one of the essential characteristics of community self-study. I agree with both McClusky (1973) and Verner (1972) that, if the participants in a community self-study do not "learn" from their involvement, the action project cannot be defined as community development. Therefore, to maximize learning, an explicit objective of a community self-study should be to seek maximum involvement of the citizens and to inform the non-joiners of the progress and consequences of the study.

McClusky (1973) has written extensively on the topic of community self-study, focusing on the method's characteristics, phases, use, advantages and limitations. What follows is a review of McClusky's writings on this subject.

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*McClusky defines information which bears on community problems "... as a source of generative power moving a community toward a better condition...modifying the direction and quality of common life" (1973: 27-28).

**General acceptance of the idea that the ISHA is one of the methods of community development practice is suggested by the fact that it is discussed in detail in a major textbook (H.B. Long, R.C. Anderson and J.A. Blubaugh (eds.), Approaches to Community Development, Iowa City: National University Extension Service and American Testing Service, 1973).

McClusky argues that it may be necessary to address two issues before a decision is made regarding who is to be involved in the process of gathering information in a community study: what types of information are to be collected, and what purpose the information is to serve. Who gathers the information may be of particular importance when the information's credibility and relevance influence the acceptance of the information.* For example, information relevance and credibility are often significant when information is translated into decision-making for change in community life.

McClusky addresses the issue of the involvement of outside experts in developing and conducting a community study. He suggests that the level of expert participation should be determined by the type of objective which the community study aims to achieve. Thus, according to McClusky, if the concern of the study is "the role of information per se, we would be justified in turning to the expert with specialized knowledge rather than to the citizen whose store of information is more elementary" (1973: 26).

On the other hand, if the community study is conducted for action planning, McClusky feels it may be undesirable to give the outside expert a "carte blanche" in designing and implementing the study. His conclusion is based on the following factors: 1) outside experts may be unable to view community issues in perspective; 2) outside experts are not always in the best position to determine priorities for problem solving; and 3) the possible existence of a credibility gap between the outside experts and the local citizens may mitigate against acceptance of the expert's findings and recommendations. McClusky therefore proposes that, where possible, citizens should either conduct a community study themselves or be involved in the various phases of a study conducted by an outside expert.* McClusky outlines four variables which bear on his proposition: participation, the role of information (already referred to), the community dimension, and the coping process (1973: 26-29).

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*In Canada, the Challenge for Change project of the National Film Board can be considered as a strategy of planned change based on these ideas.

McClusky's conceptualization of participation in community self-study resembles Lewin's notion of action research which was discussed earlier (see page 36). McClusky, however, goes further by detailing the link between participation and community development practice, and by delineating various advantages and disadvantages of having citizens participate in community study activities.

An advantage of citizen participation is that, when a group of citizens functions as a collectivity and "as representatives of the community as whole, they should be able to view things in perspective and assist decisively in the determination of priorities" (McClusky, 1973: 26).** Another advantage is the fact that, because of a network of formal and informal relationships (Warren's horizontal pattern of interaction), citizen groups may have access to data and judgments which are not easily obtained by outside experts (e.g. knowledge of who wields power). Citizens also have the benefit of experiencing first-hand the results of previous decisions. Therefore, they have a special vantage point from which to assess the possible impact of proposed change. This is not to say, however that external experts cannot adequately determine the local perspective, for often they can elicit citizen views, etc.* But a one-sided viewpoint is less likely when a group of citizens collectively pulls their knowledge together. As a result, the community study information will likely be more "relevant".

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*McClusky acknowledges that often there are risks and limitations associated with a community study conducted by citizens. For example, McClusky notes that community residents may not have "access to reliable data about the community as a whole" (1972: 29).

**McClusky fails to acknowledge that in order for citizens to "view things in perspective" it is necessary for them to have the expertise or knowledge to do so.

A community self-study may be recommended when outside experts are not available, or when financial constraints preclude the use of experts. Robinette (1968) discusses the problem facing small communities when they attempt to obtain trained planners to conduct planning studies in the field of health care delivery. His suggested remedies, which are outlined below, apply directly to the problem and objective of this thesis:

> We believed the problem might be resolved if we could find or design planning guidelines which could be used by untrained community volunteers, acting for a local decision-making body (which we could help form), composed of and representative of the effective leadership of the community...We feel a better developed set of guidelines, along the lines we have

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*My work experience as a community self-study consultant suggests that it is possible for an outsider to assess the community's viewpoint by talking to local informants.

> suggested, with minor consulting advice, will make it possible for the smaller communities of Washington and Alaska to responsibly control their own health service debt without major subsidy.
> (1968: 35)

Warren (1973) also addresses the issue of citizen participation. One of the seven factors contributing to the "great change" was said to be increasing bureaucratization and impersonalization which, according to Warren, increases the credibility gap between the decision-makers and those affected by the decision, and between outside experts and members of the community. Often, the judgment of the expert is ignored because it does not carry "credibility", whereas, if a group of citizens "gather data of their own, or endorse data collected by someone else, the probability is greatly enhanced that fellow citizens will accept the data" (McClusky, 1973: 27).

The third variable outlined by McClusky (after participation and the role of information) is the community dimension, which refers to the proportion of the citizenry which needs to be involved in a community self-study project if the project is to constitute community action or development. McClusky (1973) disagrees with the view held by some writers (Biddle and Biddle, 1965; Dunham, 1970) that, in order for an action-oriented project to be considered as community development, the project must involve at least a large number of people, possibly the whole community. Instead, he believes that, in order for the self-study to be "community oriented", the following factors should be in evidence: participants should represent the major segments of the community; meaningful participation should be open to all who wish to participate; the public-at-large should be kept informed; and the self-study should be accountable to the community.

Community self-study is an important vehicle for increasing the coping behavior of the community, McClusky's fourth variable. While the method cannot always claim to be a problem-solving method, it is always problem-oriented. In fact, the community self-study can often be used as an important avenue for reaching solutions to some problems. The implicit, and often explicit, goal of community self-study is ultimately the improvement of community life. This orientation is reflected in various academic courses in the area of community self-studies. Stinson, for instance, writes about the course offered by the Extension Division of the Algonquin College in Ottawa:

> The operative principle running through the structure of this model - the structural model for self-study - was to make it possible for citizens to become researchers of their own community around issues that were important to them.
> (1971: 252)

Mico (1965) notes that one of the aims of the Health Self-Study Project of the U.S. National Commission on Community Health Services was to educate citizens about which problems needed to be solved. The Commission hoped that citizens would be motivated to support action programs as a result of their involvement. One of the outcomes of the "educative" function of community self-study is "higher recognition of interdependence, more open and effective communication and more effective collaboration among the power figures" (Schindler-Rainman and Lippitt, 1972: 5).

To summarize to this point, the literature review has suggested a number of circumstances which warrant the use of a community self-study (i.e. when outside experts are not available or when the cost factor precludes the use of an expert or when relevance and credibility are at issue). Further, the link between specialized knowledge and power as a factor in decision-making has been noted. The merits of community self-study, however, extend beyond these task-related factors.

In addition, a number of process-related benefits are associated with the community self-study, including the following: increased problem-solving skills, increased leadership potential, new networks of partnerships, an increased number of formal and informal relationships, decreased ignorance and perceptual distortion, and the development of a sense of community. These benefits influence both those participating in the study and those in the community who are affected by decisions for change which are outcomes (directly or indirectly) of the self-study. Goulet expresses the same idea in the following:

> The survey's final goal, obviously, is to transform a populace in the very process of studying it...This idea is not new; behavioral scientists have long known that any attempt to examine a population has effects on it. The originality lies in that this fact is formally incorporated into the survey process and used as a strategy for implementing change in a participating mode.
> (1971: 164).

These process-related benefits will be readily recognized as community development goals since they strengthen the horizontal pattern of the community. If none of these process goals are observed in a community self-study project, it must be concluded that the action involved represented only community action and not community development. Accounts in the literature of completed self-study projects reveal that, in all cases, at least some of the process benefits reported here were in evidence.

Having discussed some of the merits of community self-study, I will now focus on a number of criticisms of the method. In his critical analysis of the community self-study method and its related literature, Mico suggests that widely diverging opinions exist about "practically every aspect of (community) self-studies; about why they should be undertaken; about how they should be done; and about their relative effectiveness in producing change in the community" (1965: 288). Most of the criticisms levelled at community self-study projects are directed at task performance-related aspects. Most critics, other than Woolsey,* favor, to some extent, the involvement of the ordinary citizen in the fact-gathering process.

Morris (1962) believes that self-surveys rarely produce new facts, and Mico (1965) comments that most community leaders already have a reasonable understanding of what the community's major problems are. Hunter (1955), reporting on one health self-survey, notes that it failed to produce an in-depth study or factual details. Fleck (1962) warns against the danger of thinking that the process of gathering information by itself will influence subsequent community behavior. While this warning is salutary, there are a number of accounts which suggest that the mere gathering of facts can have an immediate and future influence on community behavior.**

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*Mico reports the following: "Ted Woolsey, Chief of the PHS National Health survey, is insistent that data should be collected by experts, not by citizens. He believes that the study participants can best be used in determining what meanings that data have for their communities, and what alternative courses of action are open for decision-making" (1965: 288).

**For example, Rosenthal reports that a survey conducted in Penticton, British Columbia had a "powerful reinforcing effect in bringing a about some changes and innovations" (1972: 152).

One difficulty which is frequently encountered during a community self-study is the problem of motivating individuals or groups to become involved. The problem is generally one of motivating the traditional non-joiners; that is, members of the lower income and educational levels. Rosenthal (1972) reports this problem, and Wilson's (1968) process analysis of a number of self-studies conducted in the United States in the 1960's came to a similar conclusion. The problem of motivation is seldom mentioned in the accounts of self-study projects which were stimulated by universities. It is probable that the reason for this lies in the fact that, generally, it is only after the initiative has come from the community that the university will lend its resources to the self-study project.

McClusky believes that it would be difficult to sustain interest and involvement in a community self-study unless the members feel there is a genuine problem or need which can be documented:

> Unless a need does indeed exist, the fictitious nature of concern will soon become apparent, and it will be impossible to attract the collaboration of co-workers in sufficient numbers or with enough motivation to sustain a viable program of inquiry.
> (McClusky, 1973: 29)

McClusky's claim may contain some validity, but his statement does not always apply, as is illusrrated by the account of a self-survey provided by Sower et al. (1957). In order to conduct a country-wide community health self-survey, the assistance of hundreds of volunteer interviewers was enlisted. An analysis of the volunteers' motivation for getting involved revealed that many individuals had not given much thought to the reasons for the survey (although it should be noted that the sponsor of the survey had made few efforts to inform the volunteers of the survey's objectives).*

Another disadvantage of the community self-study method is that it requires a reasonable degree of leadership sophistication. Wilson's (1968) process analysis found that the best indicator of community health self-study success is the community's success in initiating and completing action in the past. Anderson and Burke (1959) found that communities varied greatly in their abilities to conduct self-studies and that a community's ability reservoir was an important factor relating to the success of self-study projects.

There are a number of disadvantages of community self-study which relate to the use and focus of such studies. For example, sometimes there is a danger that the study will focus (either purposely or by chance) on insignificant problems at the expense of more urgent or more important community problems. In some instances, community self-studies are misused in that they are employed as an avoiding or forestalling tactic. Other disadvantages which may mitigate against successful community self-study include the following: a climate of unpreparedness; duplication of efforts; competition with other community studies or surveys; the demand on potential participants for involvement in other community activities or special projects; agencies; exasperation due to repeated requests for data; disenchantment because of previous unsuccessful study experiences; and the length of time required to do a community self-study.

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*The interviewers gave the following reasons for participating: due to their obligation to others, out of a general feeling of goodwill for the community, due to loyalty to persons or organizations and because of an anticipation that interviewing would be a pleasant task: "... most of the participants did not understand the objective of the survey ...Consequently, they had few expectations that there would be results from the survey" (Sower et al., 1957: 196).

Some community study problems which are also applicable to community self-study have been identified by Vintner and Tropman (1970: 321-323). One of these problems is "process protocol", a term denoting excessive concern about "proper" kinds of interpersonal relationships among the study participants to the neglect of objective fact-finding. Such concern is not shared by most community development theoreticians and practitioners. Community Development theory holds that "process" aspects of community action are as (if not more) important as task accomplishment. Another problem is that of "premature truncation", which occurs when the study is divorced from action considerations, and where follow-up efforts are left to chance. Further, the problem of "rationalization" refers to situations where the study is used as a tactic for justifying existing patterns of agency behavior or service delivery.

Understanding and anticipating problems associated with doing a community self-study, and having knowledge of the advantages and disadvantages of the community self-study method, increases the change agent's ability to assist the client in successfully carrying out a self-study project.

In designing the ACHSSO, I have endeavored to apply the knowledge gained from studying the literature pertaining to community self-study. Another result of the literature review has been a consideration of the extent to which the community self-study approach "fits" within the three models of community organization outlined by Rothman (1972), the focus of the following discussion.

c. Community Self-Study: A Blending of Rothman's Models A (Locality Development) and B (Social Planning)?

To this point, this chapter has described the community self-study as being the following: action research; community action; problem-solving and change-oriented; and community development. Community self-study may also be examined according to its social planning characteristics, characteristics which have been outlined in detail by Rothman (1972). The preparation of the ACHSSO has benefited from relating the community self-study method to Rothman's writings on three models of community organization.*

Rothman's three models of community organization are referred to as locality development** (Model A), social planning (Model B) and social action (Model C). It was noted earlier that change agents tend to make certain assumptions about their client system. In like manner, certain assumptions are made in each of Rothman's three models. The assumptions relate to "the nature of the community situation, the definition of one's client population or constituency, goal categories of action, conception of the general welfare, appropriate strategies for action, and so on" (Rothman, 1972: 476).

Rothman discusses in considerable detail twelve sets of community organization practice variables which help to describe and compare the three models. The following are the twelve practice variables: 1) goal categories of community action; 2) assumptions concerning community structure and problem conditions; 3) basic change strategy; 4) characteristic change tactics and techniques; 5) salient practitioner roles; 6) medium of change; 7) orientation toward the power structure; 8) boundary definition of the community client system or constituency; 9) assumptions regarding interests of community subparts; 10) conception of the public interest; 11) conception of the client population or constituency; 12) conception of the client role (1972: 477). Many of Rothman's examples of locality development and social planning apply to community self-study.

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*Rothman also sees these models as three ideal type orientations to purposive community change.

**This term is analagous to the concept of community development.

Some examples of the practice variables which are applicable to Model A are listed below (their numbers correspond with the numbers of Rothman's practice variables noted above):

1) the process goals of self-help, community capacity and integration.
2) a concern with increasing democratic problem-solving capabilities.
3) involving a broad cross-section of people in determining and solving their own problems.
4) fostering consensus and increasing communication among community groups and interests.
5) functioning as enabler and catalyst.
6) manipulating small task groups.
7) utilizing the community's power structure as collaborators in the common action.
8) seeking the involvement of all groups in the community.
9) viewing the interests and differences of the various community groups as basically reconcilable.
10) holding a rationalist and unitary conception of the public interest.
11) viewing the client population as citizens.
12) involving the citizenry as active participants in an interactional problem-solving process.

The above examples apply to the "ideal" practice of community self-study since they are not always found in a given community self-study project. But most, if not all, of the examples may be found in a well-planned community self-survey.

There are fewer examples to be found of practice variables which are characteristic of Model B that apply to community self-study. However, the following are some illustrations:

1) the task goal of community self-study is not always that of problem-solving.
2) the assumption that there are substantive social problems is not always made.
3) although there is always fact-gathering about problems, the decisions made on the basis of the study are not always rational.
4) the basic change strategy is sometimes that of consensus, at other times, that of conflict.*
5) the "salient practitioner role" is not always that of program implementer or facilitator for some community self-studies do not act in this capacity.
6) the participants in the community self-study often place less emphasis than do social planners on the actual implementation of programs and manipulation of formal organizations.
7) the power structure is not always the sponsor of the community self-study, whereas in social planning it usually is so.
8) the client system is sometimes the total community, at other times, it is only some community segments (as in social planning).
9) interests and differences are sometimes seen as being reconcilable, and at other times, as being of a conflicting nature.
10) the public interest is viewed by the social planning model as being "idealist-unitary". This view is often shared by the community self-study group since, in establishing its action goals, the group bases its decisions on estimates and assessments of community needs.**
11) the conception of the client population or constituency in community self-study is not that of "consumer" as is the social planning model's conception.
12) Rothman writes that in the social planning model the client's role is seen as that of consumer or recipient.

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*McClusky (1973) believes that it may be undesirable to avoid conflict in the pursuit of community development and that if conflict does arise in a community self-study action, it should be faced. Significant benefits may result from conflict resolution.

**The "idealist-unitary" view emphasizes the value and power of knowledge, facts and theory in determining the public interest, although decision-making which is influenced by values cannot be completely avoided.

> This portrayal is no longer accurate, for few social planners today would hold the view that the client population is to be used only as recipients of services, and that the consumer should be excluded from the process of determining policy or goals.*

The conclusion which may be drawn from the present attempt to relate the community self-study method to Rothman's models of locality development and social planning is that community self-study contains elements of each, although more of the former than of the latter.

This chapter has focused on a number of topics related to community self-study (the nature of the community, planned change, change agent functioning, change agent-client relationship, and change strategy) which were, in turn, discussed in relationship to the functioning of the JPC and the design of the ACHSSO.

The following chapter will discuss two American health study guides and the process of designing the ACHSSO.

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*The public forums sponsored in recent years by the Edmonton Regional Planning Commission in the smaller communities surrounding Edmonton, Alberta, illustrate attempts to include the consumer in the process of policy or goal determination.

CHAPTER III

TWO COMMUNITY HEALTH SELF-STUDY GUIDES AND THE DESIGN OF THE ACHSSO

This chapter will focus on the weaknesses and strengths of two American community health self-study guides, and will discuss the activities which were involved in designing the ACHSSO. Before examining the two guides it will be appropriate to briefly discuss why it is important for a community to assess its characteristics, health needs and resources. In addition, the reasons for selecting and adapting (to the Alberta situation) the two health study guides will be noted.

The previous chapters have focused on various uses of community self-study and it was noted that, in the United States (particularly during the 1960's), many community health self-studies had been conducted. Further, with reference to the situation in Alberta, it was noted that the Alberta Hospital Services Commission (A.H.S.C.) recognized the need for rational health care planning and that such planning must be preceded by an assessment of community characteristics and of the health care delivery system.

In the following excerpt, Hochstrasser identifies why it is important to have an understanding of the community's characteristics:

> ...ecological, psychological, social and cultural factors influence not only matters of disease control and of health attitudes and behavior, but also the provision and organization of health services and the delivery and use of these services in the community. In these and other ways, then,

> health and medicine are interrelated and deeply affected by many other factors in the community.
>
> Health activities, including all forms of medical care, must be viewed in relation to all other aspects of the community; location and physical setting, economy and wealth, agriculture and industry, business and commercial interests, social class and politics, education and recreation, transportation and communications, all influence health and medical care.
> (1967: 1)

The objective of community health self-study, therefore, is to achieve an understanding of the various aspects of community life and structure that are related to the "identification and solutions of the health and medical care problems of the people in the community" (Hochstrasser, 1967: 1). The achievement of this objective requires systematic and comprehensive study which is facilitated by knowing what questions to ask, and where and how to obtain the answers.

In the previous chapter, it was noted that many recent textbooks on public health nursing practice contain a chapter on community assessment. None of these chapters in themselves constitutes adequate guidelines for systematic and comprehensive community health self-study. There are, however, a few health study guides designed for use in the United States which outline what should be studied and how this should be accomplished. In this chapter, the strengths and weaknesses of two such health study guides will be examined. One of the guides, the "Community Health Study Outline " (to be called the Kentucky Guide), was designed by Hochstrasser and other staff of the Department of Community Medicine of the University of Kentucky, for use in the state of Kentucky. The other guide is "A Self-Study Guide for Community Health Action-Planning" (to be called the APHA Guide), which was published by the American Public Health Association and designed for use in various states.

These two guides have been selected because they complement one another and because of the few health study guides available (This judgment is based on my knowledge of what various writers have noted about community health study). The strength of the Kentucky Guide lies in its sections concerning the "how to" and "what" of studying health-related community characteristics, characteristics which are given only cursory attention in the APHA Guide. The strength of the APHA Guide, on the other hand, lies in its treatment of the organization of health care delivery and of the various sub-areas of health. The design of the ACHSSO has borrowed the best aspects of both of these guides, and has built on them where neither was adequate.

Hochstrasser's (1967: 1) comment that the provision and organization of health services are affected by ecological, psychological, social and cultural factors can be illustrated by noting the difference in the types of health care delivery systems operating in Canada and the United States. Such differences have implications for the utility of existing health study guides since guides designed with one geographical area in mind may not be useful in another geographical area. Another factor which detracts from the usefulness of existing health study guides is that, even within the "community of solution"* for which the particular guide has been designed, changes in the health care delivery system occur over time, a factor which decreases the usefulness of older guides.

Attention will now focus on a discussion of the characteristics, assets and limitations of the Kentucky Guide and the APHA Guide.

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*"Community of solution" is defined on page 61.

A. The Kentucky Guide

1. A Summary of the Kentucky Guide

The Kentucky Guide was designed for use by students of the Department of Community Medicine of the University of Kentucky. The Guide is characterized by a number of assets as well as some weaknesses. In terms of the organization of the material there is much to commend. The introductory paragraphs address themselves to the interrelationship between health (or the development of disease patterns) and psychological, social, cultural and ecological factors, followed by a brief discussion of the orientation, objectives, general approach and methods of the community health study. Next, the Guide briefly discusses what general resources tend to be found in every community, and a listing of such sources is provided (e.g. doctors, medical clinics, hospitals, health departments, government agencies, civic and professional organizations, etc.). Having thus prepared the health self-study practitioner with some basic background, the Kentucky Guide suggests what things the practitioner should be looking for in studying the community of solution.

The remainder of the Guide is divided into the following sections: introduction to region, demographic data on the county, vital statistics, organization of health services, the local hospital, extended care facilities, public health services, community diagnosis, recommendations and plan of management. Except for the last two sections, the layout of the material forms three columns having the general headings of: "General Orientation and Source Material", "Local Situation", and "Analysis and Interpretation". The layout is as follows:

SECTION: ____________

General Orientation and Source Material	Local Situation	Analysis and Interpretation

The first column contains information providing a background to the questions asked in the second column and, where appropriate, the column contains references to resource materials. In the second and third columns, spaces are left for recording answers. Unfortunately, there is little space within these columns to include the answers and therefore the Guide cannot be used in its original format for reporting purposes. It is necessary to record answers on separate paper (as I learned when using the Guide several years ago). During the initial stages of designing the ACHSSO, I planned to adapt the Kentucky Guide to Alberta conditions. Thus, I aimed to retain the most positive aspects of the Guide's layout, in that by having the three columns situated adjacent to one another so that the questions, background material, and answers could be easily linked to one another. Since it is not possible to have the three columns on one page and still have enough space for recording answers, the next best solution seems to be to have the first and third columns on the same page, and to have the middle column (i.e. the one where the answers are filled in) on a page overleaf. It would then be relatively easy to make copies of what would, in fact, be the study report.

The design of the ACHSSO follows the same format employed by the Kentucky Guide although the heading of the first column has been altered to read "Introductory Comments and Sources of Information". Further, in the third column of the Kentucky Guide, space is provided for answers, but in the ACHSSO Guide, all items from the third column requiring an answer are moved to the "Local Situation" column on the right hand page.

2. Limitations of the Kentucky Guide

Since the Kentucky Guide's format shortcomings were noted in the previous section, the following discussion will focus on the content shortcomings. An important weakness of the Kentucky Guide is its dearth of guidelines for examining the non-hospital-based health services. The Guide does provide some suggestions for examining the beds and personnel situation of hospitals (including extended care facilities), and for ascertaining the number and types of health practitioners practicing in the community. The Guide suggests that public health services should be examined, however, it does not provide guidelines as to what factors should be considered in the assessment. Also, the Guide does not provide adequate guidelines for organizing a community health self-study carried out by groups.

A second limitation of the Kentucky Guide is that it is designed to take into account the specific conditions and information of Kentucky and the United States. This is, of course, a strength as far as its use in Kentucky is concerned, but it creates problems when using the Kentucky Guide in Alberta. The following are some examples of content from the Kentucky Guide which illustrate the need for adaptation to Alberta conditions.

References to maps and regions, and to specific government assistance plans, have to be "translated", as do references to State and Census data (e.g. for example, the occupational categories in the U.S. Census differ from those used in the Canadian Census). Further, the Kentucky Guide suggests that the study report should indicate the distance between the county seat and the nearest community having a population of "one million; 500,000; 100,000; 25,000; 10,000; and 2,500 to 10,000." These figures are inappropriate because of the population sizes of communities in Alberta (i.e. there are few cities in Alberta having populations over 100,000). Thus, different population categories which take into account the size of Alberta communities are required.

A third limitation of the Kentucky Guide is that, in the column "General Orientation and Sources", the background information is often inadequate to serve as a guide for obtaining demographic data which the Guide suggests should be obtained. For example, the Guide recommends that income, education, housing, and other social and economic data be obtained, yet the user is not advised as to which sources could provide the data. Also, the suggestions presented in the column "Analysis and Interpretation" are generally cursory.

A fourth limitation of the Kentucky Guide is that its suggestions for obtaining demographic data are directed chiefly at the county level to the neglect of presenting suggestions for gathering data applicable to the communities within the county.

3. Assets of the Kentucky Guide

Although the Kentucky Guide was designed for the use of students of the Department of Community Medicine of the University of Kentucky, it has general usefulness for other individuals or groups interested in studying the characteristics of the community in Kentucky.

An important asset of the Guide is that its suggestions for obtaining demographic and socioeconomic data cover a comprehensive range of health-related factors. For example, the Guide asks questions about transportation, size of county, population, sex ratio, education, household and housing status, income, employment, industry, agriculture and vital statistics.

Another asset of the Guide is its stated approach to community study, which involves an examination of the "community of solution"* from three perspectives: the regional, the county, and the municipality (however, the Guide fails to develop this approach). In terms of its applicability to the Alberta scene, this is an excellent approach, because many hospital districts cover one or more counties, and several communities of differing sizes. An advantage of asking questions from these three perspectives is that if information is unavailable for one locale, it may be available for another. Another advantage of viewing the community of solution from these three perspectives is that it influences the student of the community to focus on the interrelationships between the various political-geographical jurisdictions.

A final asset of the Kentucky Guide is that, because of its action orientation, it aims to be a practical guide. This action orientation is reflected in the Guide's final section which stresses the importance of making practical recommendations for a plan of management.

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*The concept "community of solution" is described as follows: "Planning, organization, and delivery of community health services... must be based on the concept of a 'Community of Solution' —that is, environmental problem sheds and health service marketing areas, rather than primarily on political jurisdictions" (National Commission on Community Health Services, 1966).

B. The APHA Guide

1. A Summary of the APHA Guide

The complete APHA Guide consists of two volumes, the first of which provides guidelines for assisting a health self-study group to organize its study activities, and for helping the study group to identify health care problems which warrant further in-depth study and action. The second volume provides guidelines for focusing on areas of concern which were identified in the initial study effort (i.e. the first volume) as being in need of more detailed study.

The Guide, which represents the third edition of a health self-study guide published by the APHA, was extensively field-tested before it appeared in its final form.* A special advisory committee provided expert advice regarding the design of the Guide, and a number of modifications and new ideas recommended by the health study groups of the communities used for field-testing the Guide were incorporated. In this thesis, only the first volume of the APHA Guide will be examined according to its assets and limitations. The second volume is so detailed in its suggestions for community health self-study that a critique would require expertise in the fields of medicine and health services administration. I do not possess the expert knowledge required, and I consider the first volume adequate for the purpose of conducting an initial study of health and health care problems in the community. To adapt the second volume to health and health care conditions in Alberta would more appropriately be an undertaking for health care administrators than for community development practitioners.

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*This field-testing took place in 21 communities conducting a health self-study in cooperation with the Community Action Studies Project of the United States National Commission on Community Health Services (NCCHS). The NCCHS was established in 1962 as a temporary, independent, non-profit organization, and was sponsored by the A.P.H.A. and the National Health Council.

The first volume is divided into two parts. Part A contains material which is relevant for the effective organization of a community health self-study. It stresses the importance of effective organizing for health self-study, and emphasizes the need for using an interdisciplinary approach. It addresses itself to the meaning of the term "community", and to the need for a broad representation on the study group. It suggests that the group should include representatives of the health professions, health agencies, business and labour groups, and other community interest groups.

Part A then focuses on the approaches which can be employed for organizing the study. It is suggested that a steering committee and a number of study sub-committees be established, and that the participants should take cognizance of the action or follow-up phase of the study throughout the study process. Part A then focuses on the results of a process analysis of the community health self-studies conducted in 21 communities.* This discussion is followed by an overview of the various organizational patterns which were observed in the health self-studies of the 21 communities, and a number of organizational factors considered to have made a significant contribution to the success of the health self-studies are noted. Part A concludes with a brief discussion of the topic of budgeting for a community health self-study.

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*The findings were reported by Robert N. Wilson, Community Structure and Health Action: A Report on Process Analysis. Washington, D.C., Public Affairs Press, 1968.

A few introductory paragraphs in Part B focus on a number of approaches which a community health self-study group could take after completing an initial assessment of the health and health care status of the community. The Guide stresses that the questions of Part B are meant to provide a frame of reference to be used for assessing the level of health care delivery in the community, as well as to help the study group identify the salient health service problems.

The questions relating to the community's health and health care services are organized under the headings of: Questions about the Community and its Organization of Health Services; Questions about Administration of Health Care Services; Questions about Personal Community Health Services; Questions about Environmental Health Services. Part B closes with a list of selected references and sources of information.

2. Limitations of the APHA Guide

The greatest weakness of the APHA Guide is its cursory treatment of how to study the community. In the section "Preliminary Activities", the Guide gives the following suggestions of the information needed in obtaining an overview of the community: population trends, planning for some selected community services, and living standards. Further, the group is urged to define the geographic area to be covered by the study, and to list the cities, towns, and counties located within the geographic area. Several additional suggestions for studying the community are made, such as collecting basic reference materials about the community, and identifying health facilities outside the community of solution where residents from within the community of solution go to obtain services.

A second weakness of the APHA Guide relates to the fact that it was designed specifically for use in the United States, and therefore is limited in its use in Alberta. As a result, much of the material in Part B regarding the organisation of health care services and the planning of health care services must be adapted if the material is to be of optimal use in Alberta. Specifically, adaptations are required for the following reasons: because of different terminology; because the sources of information differ; and because the system of health care delivery in Alberta is more uniform than it is in the United States.

An important difference between the delivery of health services in the United States and that in Alberta lies in its financing. Further, the types of medical care programs offered for special groups differ. For example, there are a number of programs in the United States which exist because of Federal laws that are inapplicable to Alberta (e.g., Military Dependent's Medicare and the Veteran's Administration programs).

A third weakness relates to the fact that health and other value attitudes change over time and because of new knowledge in the fields of medicine and health care delivery, adaptation of the Guide is required. The Guide provides an excellent comprehensive coverage of health sub-areas, although it omits the subjects of nutrition and family planning. It is quite likely, however, that these areas would have been covered if the Guide had been designed ten years later.

To illustrate the need for adapting the Guide, it will be of interest to focus on the health sub-area of venereal disease control. In the Guide (page 53) the narrative explanation states:

> The incidence of infection is alarmingly high in youth of all social classes, due to sexual promiscuity...Promiscuity, prostitution, and homosexual activities are major factors in the spread of these diseases. Police cooperation is needed to suppress or eliminate prostitution.

These comments might have applied to the United States in the early sixties, in that they were consistent with the facts and with society's values, but at present in Alberta (and in North America generally) they are neither factually correct, nor consonant with current societal values. (In Alberta in the mid-seventies, it is not the youth age group which has the highest incidence of infection, but the 20 to 24 age group. Also, it is factually incorrect to state that prostitution in Alberta is one of the major factors in the spread of venereal disease).

In conclusion, changes are necessary in each of the Guide's sections dealing with a particular health sub-area because of the development of new medical knowledge, and in order to take into account the specific health care conditions and sources of information which pertain to Alberta.

3. Assets of the APHA Guide

One of the strengths of the Guide lies in the fact that, because it is the end-product of the application of previous health self-study guides over a period of several years in a large number of communities, it has benefited from the test of practical experience. Another asset is the Guide's excellent organisation of the material presented. A group using the Guide is discouraged from proceeding immediately to the task of assessing health services; rather, it is advised to first consider how the members may best be organized in order to accomplish the task goal. The Guide's recommendation that the study committee should be representative of the community and should include individuals who could influence the implementation of the study group's recommendations, reinforces (potentially, at least) the group's feeling that their task is not simply an academic exercise, but is oriented toward planned change. The Guide thus complies with a maxim of community development, that is, it is important for the participants in community development work to understand what they want to accomplish and why they want to accomplish it.

The organization of the material in the Guide (in Part B in particular) is excellent. The headings utilized throughout the Guide indicate good ordering of the material. Before one can adequately answer questions about the adequacy of health care services it is necessary to have knowledge about the services which are (and are not) being delivered, and about how they are planned, organized, and coordinated. A useful feature of the organization of the material is that enquiry areas are delineated in a clear fashion and grouped separately. For example, questions relating to acute hospitals are grouped together in one section, while those related to extended care facilities are grouped together in another section. The same organization of the material has been followed in the ACHSSO.

Another excellent feature of Part B of the Guide is the provision of a narrative explanation about each particular health sub-area, and the inclusion of information regarding sources of information and references for further information. These narrative explanations not only inform the Guide's users about salient aspects of the study area, but they are also educational. The lay members of a community health self-study group, for instance, would undoubtedly find a great deal of new information in these narrative explanations.* As the narrative explanations provide an orientation to particular study areas, the narrative explanations have been placed under the heading of "Introductory Comments and Sources of Information" in the ACHSSO.

Taking into consideration the various assets and limitations of the Kentucky and APHA Guides, the following section will focus on the design of the ACHSSO.

C. The Alberta Community Health Self-Study Outline

1. Preliminary Activities in the Design of the ACHSSO

The present section will discuss the steps taken in designing the ACHSSO. In Chapter I, I noted that during my field placement for the M.A. Program in Community Development, I was involved in a study of community resources pertaining to mental health in Vegreville, Alberta. During this time I became familiar with the Kentucky Guide, the contents of which proved to be of considerable value in doing the study. As a result of my exposure to the Kentucky Guide, I decided to do a comprehensive community health study of Vegreville.**

Following my field placement, I concentrated my studies in the area of community self-study, and discovered the writings of Lippitt et al. (1958); Sower et al. (1957); Warren (1973); and the APHA Guide (1967). After studying the APHA Guide I realised that it was characterised by shortcomings which, in several respects, made it inadequate as a guideline. As a result, the idea of adapting the Kentucky Guide and the APHA Guide to Alberta conditions emerged.

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*In the Kentucky Guide, the content listed under the heading "General Orientation and Sources of Information" probably serves lay members in a similar manner.

**The report of this study was forwarded to the Medical Officer of Health in Vegreville, for the use of the Joint Planning Committee (JPC) of the Minburn-Vermillion Hospital District, Alberta.

The next step was to check with personnel from the Alberta Hospital Services Commission and the Department of Social Services and Community Health in order to determine if an adequate community health self-study guide for use in Alberta already existed.*

Library research yielded little further information on the existence of community health study guides for use in Canada. The research did, however, acquaint me with the community health nursing literature, and its advocacy of community health assessment. This literature provided me with "checkpoints" to ensure that the ACHSSO would indeed become a comprehensive health self-study guide.

2. Actual Design Activities

Once acquainted with the field of community health self-study, I began the task of adapting the Kentucky Guide and the APHA Guide. As a first step, I outlined a number of principles which would serve as guidelines in the design.

The first principle was that the ACHSSO should be comprehensive, so that the JPCs utilizing it would, as a result, be able to do an adequate assessment of community characteristics having a bearing on the health of the community. Further, comprehensiveness would mean that the ACHSSO would enable an initial assessment of the total spectrum of health services delivery so that its strengths and weaknesses could be highlighted. Influenced by the APHA Guide, I felt that, while the ACHSSO should be a comprehensive guide, it did not have to strive for great depth in its enquiry. If weaknesses in the health care system were discovered through an initial assessment using the ACHSSO, and it was felt that if further in-depth study was required, the JPC could establish an "expert" committee to investigate the problem area(s) identified.

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*I was informed that this was not the case, and was encouraged to adapt a community health study guide to the Alberta health care scene as it was felt that such a guide would be of considerable value to the Province. In addition, staff of the Health Services Administration Division of the Department of Community Medicine, and of the Faculty of Nursing, University of Alberta, were unaware of the existence of comprehensive community health study guides designed for use either in Alberta or Canada.

A second principle guiding the design was that Part I and Part II of the ACHSSO should be independent but complementary entities. The rationale underlying this principle was that Part I should also be of value to the particular needs of a community's non-health planning bodies. It has been my work experience that planning bodies in many rural communities* frequently lack access to information about the community's structure, information which they feel would assist them in their planning. Thus, in order to increase the utility of the ACHSSO, Part I was designed as a self-contained guide, so that planning bodies, and individual community workers, could use it as a handy manual for doing community self-study.

Designing Part I of the Guide as a separate entity should also be of benefit to the functioning of the JPCs, as there are indications that the JPCs would be more likely to fulfil their mandate (i.e. to conduct a health care study) if the non-health professional members of the JPCs felt that the information obtained about the community would also be of value to the organization or profession they represented or identified with. In addition, it was felt that, as a result of participating in the community health self-study, JPC members and others would increase their knowledge of the community, and that such knowledge would enable them to work more effectively in their regular work situations.

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*Examples of planning bodies are the following: library and preventive social service boards; personnel providing social services; recreation boards; and town councils.

A third principle guiding the design of the ACHSSO was that, where applicable, material from the Kentucky Guide and the APHA Guide should be borrowed freely.* To me, it seemed fruitless to duplicate what others had already accomplished and tested against experience.

A fourth principle, or set of principles, was that the questions asked should be relevant to health care planning, and that when the reason for asking a question was not self-evident, background information should be supplied. Further, where appropriate, sources of information should be listed.

3. Designing Part I of the ACHSSO

The design of Part I was influenced by the knowledge I acquired during my field placement. For example, I was made aware of the fact that questions pertaining to demographic data should take into consideration the types of information available in Canada (i.e. the census data from Statistics Canada; demographic information from the Alberta Bureau of Statistics and from the Alberta Hospital Services Commission, etc.).

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*As was noted in Chapter I, copyright permission to use these guides was obtained.

The design of Part I followed the general approach to community health study which is advocated by Hochstrasser in the Kentucky Guide: that is, to systematically enquire about the regional setting and local situation of the hospital district, its county(ies) and communities (1967: 2). However, the content of the Kentucky Guide has been expanded for adaptation for the ACHSSO, particularly in the section dealing with an assessment of the communities.

4. Designing Part II of the ACHSSO

The design of Part II of the ACHSSO is based chiefly on the first volume of the APHA Guide, although some adaptations were necessary. The layout of the APHA Guide was changed in two ways. First, the narrative information in the ACHSSO is organized in two columns under the headings "Introductory Comments and Sources of Information" and "Analysis and Interpretation". The narrative material in the APHA Guide was not organized according to headings. Second, in the ACHSSO, all the pages used for reporting findings were those on the left-hand (to facilitate their clear presentation). In the APHA Guide, findings were reported on either side of the page.

Changes were also made in the content of the APHA Guide. For example, the tables were altered in length and in wording. The format for reporting findings (mainly in table form) is similar in both guides.

In adapting the material from the APHA Guide for the ACHSSO, I drew on my previous work and study experience as a psychiatric nurse, and on my readings in the fields of public and community mental health.

All sections of the ACHSSO were verified by knowledgeable personnel within the various branches and divisions of the Department of Social Services and Community Health, the Alberta Hospital Services Commission, and other government departments providing health-related services. Many of the suggestions made by these personnel were incorporated.

Two health sub-areas, family planning and nutrition, were not covered by the APHA Guide but are dealt with in the ACHSSO. The only health area not covered in the ACHSSO but included in the APHA Guide is radiological health. Health professionals whom I consulted in Alberta felt that it would not be relevant to cover this area since radiological health is strictly regulated and supervised.

CHAPTER IV

SUMMARY AND CONCLUSIONS

The focus of this thesis was community self-study and the functioning of health and allied professionals as change agents. The general problem addressed was that these professionals often lack the knowledge required to study their community in a systematic and comprehensive manner. Likewise, various planning bodies at the local level, particularly in smaller communities in Alberta, have difficulty in quantifying and documenting community needs.

This general problem is illustrated in the functioning of the Joint Planning Committees (JPCs) of hospital districts of Alberta. The JPCs have been given a specific mandate to conduct a study of the health needs and resources of the community, but most are not able to fulfil the mandate because they lack the knowledge to do so. The JPC's difficulty in fulfilling their mandate was the specific problem to which the thesis addressed itself. The particular goal of the thesis, therefore, was to design a community health self-study guide (the Alberta Community Health Self-Study Outline, or ACHSSO) which would provide a comprehensive framework to enable the JPCs to achieve their goal. Although the ACHSSO was designed for a specific target group (the JPC), the Guide has broader application as it can be used by other groups not confined to health study and planning.

The formation of JPCs represents the application of the community development approach to planned change because the JPCs represent acceptance of the principle of citizen participation in the delivery of health care services and, secondly, because the JPC's membership configuration encourages a multidisciplinary approach to solving health and health care problems.

The specific objective of the thesis stems from an application of a particular method, namely, community self-study. In the thesis, community self-study was defined as community study initiated and conducted by members of the community _for_ the community. It was noted that the community self-study method is also known as the "information self-help approach" to community development (McClusky, 1973) and as "participation-survey" (Goulet, 1971).

A second objective in designing the ACHSSO was to provide an instrument which would have a community development, as well as a health care planning, facilitating function. This objective required the application of an interdisciplinary approach to health care planning. This approach, in turn, required the examination of a number of topics, including planned change, change agent functioning, community action, community study, and community development. The second objective also required the application of a general knowledge of a number of health sub-areas (e.g. mental health, chronic disease, sanitation), and of the organization of health care delivery in Alberta. The thesis' discussion of the assets and limitations of two American community health study guides, and of the design activities of the ACHSSO, illustrated the application of this general knowledge. .

Of significance to the functioning of the JPCs and the design of a community health self-study guide is the relevant literature pertaining to planned change and community self-study. The thesis examined in some depth the writings focusing on planned change and the functioning of professionals and planning bodies as change agents by Lippitt et al. (1958), Rogers (1972), and Warren (1973).

Lippitt et al's (1958) contribution to an understanding of planned change and change agent functioning was their analysis of the assumptions made about client systems (the individual, the face-to-face group, the organization and the community). Their observation that the clients' problems fall within two main categories: those of "internal processes" (internal relationships) and "external relationships" was another important contribution. The views regarding change agent functioning and planned change were applied to the following topics: the establishment of JPCs in Alberta; the problem of improving inter-community communication; problem-solving; and the design of the ACHSSO.

The review of the writings of Rogers (1972) focused on his views concerning the change agent-client relationship; the importance of strategy in bringing about planned change; and change agent functions operating at various levels of the development of planned change. Rogers' conception of the functions of a change agent were applied to the JPC and to the printed word. It was argued that the ACHSSO can be considered as a change agent, and as a tool enabling users to be their own change agents and to possess a greater degree of self-reliance.

Warren's (1973) concepts of the horizontal and vertical patterns of community interaction were considered to have value for an understanding of the nature of the community and of the functioning of health professionals. The establishment of the JPCs illustrates the operation of the vertical pattern, and the effective functioning of the

JPCs portrays the operation of the horizontal pattern. According to Blum (1974), health professionals have become too "vertically" oriented. Therefore, the participation of health professionals in a planning body such as the JPC may result in an increased "horizontal", and consequently more balanced, orientation to health care planning.

The relationship between community self-study and community action was explored in some depth. A salient finding was that community health self-study is one form of a class of community action which Poplin (1972) refers to as planned or initiated community action. Another finding was that, in community action many segments of the community are involved and the action is characterized by a strong orientation toward the achievement of planned change.

The thesis focused on the "why, who, what, where, and how" of community self-study. The theme of community self-study being action research was highlighted by the discussion of the relevant writings of Goulet (1971) and Schindler-Rainman and Lippitt (1972). The importance of the role of information in the planning for change was discussed by noting McClusky's (1973) analysis of community self-study. McClusky's writings were singled out because they presented a thorough analysis of the advantages and disadvantages of having citizens themselves, rather than experts, conduct a study of their community. The role of information, participation, the community dimension, and the coping process are four variables identified by McClusky as operating in community self-study.

An exploration of the advantages and disadvantages of community self-study stressed the importance of the process goals of community action. This analysis noted that motivating individuals or groups to become involved is a generally encountered problem.

Following examination of the community self-study as community action and as an approach to community development, the thesis related the community self-study method to two of Rothman's three models of community organization. It was concluded that, in the characteristics of the community self-study method, a blending of Rothman's models of locality (community) development and social planning (1972) could be discerned.

In Chapter III, the discussion focused on the importance of community assessment for rational health care planning, and on the assets and limitations of two community health study guides, the Kentucky Guide (1967) and the American Public Health Association's Health Self-Study Guide (APHA, 1967). It was noted that neither was, by itself, adequate as a comprehensive guide for the JPC. The Kentucky Guide lacks the detail required for a comprehensive study of the health needs and resources of a hospital district. The APHA Guide provides inadequate guidelines for assessing the community's health-related characteristics. Furthermore, both Guides were considered to be in need of adaptation because of their American orientation and because of new knowledge, innovation and change in health care practice.

The ACHSSO is attached as an appendix to the thesis. It represents, in terms of time, energy and objectives the most significant part of the thesis. Whether the efforts expanded in drafting the ACHSSO have been worthwhile will depend on whether or not the ACHSSO will be used by JPCs or other individuals or groups in Alberta. Only then will it be possible to assess the degree to which it is of assistance in facilitating and encouraging planned change. I am satisfied, however, that the ACHSSO does provide a valuable guide to both the assessment of community characteristics and the assessment of the health and health care of hospital districts in Alberta. This claim is made on the basis of personal experience using the Kentucky Guide in Vegreville, Alberta, and on the basis of comments made by the health professionals who reviewed and commented upon the sections contained in Part II of the ACHSSO.

The thesis recommends that copies of the ACHSSO be made available to the Alberta Hospital Services Commission for distribution to the JPCs in all hospital districts. It is further recommended that copies be made available to the Research and Planning Division of the Department of Social Services and Community Health with a view to assessing the Guide's value for wider use by various Departmental managers working in the field of health and social services.

It is also recommended that graduate programs in community development, social work, recreational administration, health services administration and community health nursing programs should ensure that the curriculum provides for all students to be exposed to course content which would enable the students to assess quickly, systematically, and comprehensively, the nature of the community in which they work.

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APPENDIX

THE ALBERTA COMMUNITY HEALTH SELF-STUDY OUTLINE

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PART I

THE STUDY OF COMMUNITY CHARACTERISTICS

SECTION A: An Overview

A.I Introduction

During the 1960's in Alberta, as well as in other provinces of Canada, significant improvements were made in the health care delivery system. These improvements were accompanied by escalating costs which, if characterized by a similar rate during the seventies, would place an intolerable burden on the economy of the Nation.

In 1971, the Alberta Government created the Alberta Hospital Services Commission (A.H.S.C.), a body which was to assume responsibility for the administration of the Alberta Hospitals Act, the Alberta Nursing Homes Act and the Homes for the Aged Act, thus centralizing control over health care provided within various types of health care facilities.

Concerned about the isolation of hospital-based hospital services from other forms of health care services, the A.H.S.C., during its first few years of existence, acted upon this concern by suggesting to each hospital district board that it appoint a Joint Planning Committee (JPC). These committees are to assist the boards in the planning and evaluation of short and long-term programs, and to engage initially in an assessment of the health needs and resources of the hospital district. A brochure entitled "The Joint Planning Committee: Terms of Reference, Structure, Aims, Objectives", issued by the A.H.S.C. in 1973, outlines in some detail the viewpoints of the A.H.S.C. regarding the functioning of the JPC. This brochure expresses the Commission's belief that in order to ensure effective and efficient health care services — services which are at the same time relevant to the health needs of the community — community involvement in the planning of health care services is a necessary and integral part of comprehensive planning. The brochure, while it broadly outlines the mandate of the JPC, is not sufficiently detailed to serve as a clear and useful guide for achieving the goal of assessing the health needs and resources of the hospital district.

The purpose of the ACHSSO is to complement the brochure and to provide a "how-to"manual for the JPC. The design of the ACHSSO is such that it enables a JPC to conduct a community health self-study in phases. The JPC could use only the first part of the ACHSSO and confine its study activities to an assessment of the community's characteristics; or, it could use Part II only and study the administration of health care services in the hospital district, the personal community health services, the environmental health services, or just one or two of these areas of health care study.

The data obtained through a study of the community factors related tohealth and health care planning will also be of value to other planning areas, (i.e. planning for recreation, preventive social services, municipal planning) and to community organizations and individuals providing a service to the community. As a result of the data, the latter would become more knowledgeable about the community and their effectiveness in their work setting would be increased.

A. 2 The ACHSSO: Orientation and Objectives

This community health self-study outline has been developed in accordance with certain beliefs and values about health and health care. The orientation which guided the development of the ACHSSO includes the belief that ecological, psychological, and social factors influence matters of disease control and health attitudes and behavior. They also influence the provision for, and organization, delivery and use of, health services in the community.

Health activities, including all forms of medical care, must be viewed in relation to all other aspects of the community, such as the following: location and physical setting; economy and wealth; agriculture and industry; business and commercial interests; social class and politics; education and recreation; transportation and communications.

The ecological orientation underlying the development of the ACHSSO recognizes that man is man in habitat. It would be impossible to understand the health and health behaviors of man without an understanding of man's interaction with his environment. People affect and are affected by the environment in which they live.

In studying the hospital district, the county, the city, the village or some other area as a community, one is studying a geographic-political unit. Further, in studying a community, it is the people as recipients of health services that are of primary interest. People are, ultimately, the final concern of community health study. But if the levels of health and medical care of the people are to be improved, there is also the need to look beyond individuals and families to larger groups, and ultimately, to the whole community of which they are a part.

In summary, a major objective of a community health study is to understand the physical, psychological, and social aspects of the hospital district, the county, the incorporated municipality, or other area as they relate to the identification and solution of the health and medical problems of the people in the community. The first part of the ACHSSO has been designed to guide the JPC in doing a study of the community's characteristics in order to obtain the information needed to make a sound assessment of the local people and their health needs.

A. 3 Approach and Methods

One approach to community health self-study is that of a systematic enquiry into the regional setting and local situation of the county, town, village, or other geographic-political unit under consideration. The primary purpose of the enquiry is to provide the JPC with general knowledge of the community which is necessary for making a diagnosis of its major health and medical care problems. The resulting diagnosis, in turn, is necessary for recommending a course of action for the treatment and/or prevention of these problems.

The basic methods for obtaining health study data are, 1) utilizing information from available resources and, 2) gathering new information. Throughout the ACHSSO, a number of information resources which may guide the JPCs are identified.

A. 4 Organization of the ACHSSO

The ACHSSO is divided into two parts: Part I is concerned with the diagnosis or assessment of the community, while Part II focuses on an assessment of the community's health care organization, the personal health services, and environmental health services.

Part I is divided into five sections. Section B deals with questions about the region in which the hospital district is located (e.g. climate and economic base). Sections C and D contain questions concerned with demographic and other data to be gathered for the hospital district. Section E contains questions about demographic data to be gathered for the County(ies) covered by the hospital district. Section F focuses on guidelines for studying the various communities within the hospital district.

Part II begins with a discussion of health and health services identification, and then focuses on the reasons for including the various questions of Part II. It also focuses on the various approaches which the JPC might adopt in studying health and health services problems.

A. 5 Community Studies

Community studies have been conducted for many decades and for many reasons. They may be distinguished in terms of 1) their focus of enquiry (i.e. whether the study's focus is broad or narrow), and 2) whether the study is carried out by experts for the community, or whether the study is done by the community. When a community study is initiated and executed by a group of people who are members of the community in which the study is undertaken, and when this group is not conducting the study as their routine professional activity, the study is known as a "community self-study". When the study includes doing a survey of the community, the study is known as a "community self-survey".*

A. 6 Distinguishing Features of a Community Self-Study

A community self-study is usually initiated by a small group of community members who have identified one or more problems of the community which they want to study in greater detail. This small group may be considered the "initiating set" of the community self-study.

Often, after identifying one or more problem areas for study, members of the initiating set will involve other members of the community in the planning and execution phases of the study. For example, they could seek the opinions of influential and knowledgeable community members regarding specific problem areas, and whether there is a need to study these problems. This second group of community members is often referred to as the "legitimation set". In this context, legitimation means that the influentials and/or knowledgeable individuals sanction or legitimate the action proposed (e.g. the community self-study or self-survey) as being in the interest of the community.

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*The terms "community self-study" and "community self-survey" will be used interchangeably as it is not always possible to make a sharp distinction between the two types of activities. Generally, the term community self-survey is used to denote a community self-study which includes doing a survey of the attitudes and opinions of the members of the community.

The action proposed by the initiating set, and subsequently sanctioned by the legitimation set, may be considered as the "charter" of the "sponsoring set" (which includes members of both the initiating set and legitimation sets). Individuals agreeing upon the charter (the common goal) may do so for various reasons.[*]

The sponsoring set, having agreed upon the charter, will then be able to start planning for the community action project. Often, they will establish a steering committee to guide them. When the project is a community health self-survey there is a need to involve more individuals than are needed for a self-study in order to successfully complete the survey.[**]

In community self-study, outside experts are often called upon to provide advice about details of the study. These outsiders function in the role of consultants, and not as directors of the study.

When a study or survey is conducted by the community, rather than for the community, there is a better chance that the individuals involved in the study will want to see the findings acted on. The study activity is always considered to be a preliminary to the follow-up phase, where action is undertaken to correct or ameliorate the shortcomings identified in the community self-study. (The concern with follow-up is an important feature of the community self-study process, and allows the community self-study to be classed as "action planning").

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[*] For example, when the charter involves conducting a community health self-study, senior hospital personnel may participate because such a study may enable them to learn what the age structure of the community is now compared with ten years ago. A recreation director may participate because he/she realizes that the demographic and population data obtained will be useful in planning for future recreational programs.

[**] It is by no means unusual for several hundred people to be involved in the execution phase of a community self-survey. In one county in the United States, the sponsoring set was able to involve more than five hundred citizens in the task of interviewing a majority of the households in the county.

In community self-study, the knowledge that accrues to the participants of the action (what are termed the "process" goals) are considered to be as important as the fact-finding (i.e. the "task" goals).

A. 7 Organizing for a Community Health Self-Study

The community self-study literature provides many analyses of self-study projects undertaken in Canada and the United States. During the early 1960's in the United States, the National Commission on Community Health Services provided the impetus for a number of community health self-studies. Under the Commission's auspices, a team of researchers analyzed the action process of health self-studies conducted in 21 communities (the communities were representative of various sizes and regions). A number of significant findings about community health self-study emerged from these intensive analyses. The following provides a summary of the salient factors which were found to influence the success of community health self-studies:

1) size of the community was an important factor. A population in excess of 250,000 presented a constraining force to the self-study process. The implication of this finding for Alberta is that only in Edmonton and Calgary would it be difficult to conduct a successful community health self-study.

2) the existence of a basic agreement on the broad aims of the study.

3) some emergent awareness of the importance of good health to the well-being of the community.

4) the existence of some level of community pride.

5) a recent history of successful resolution of some community problem(s).

6) the availability of an individual willing to function as the self-study coordinator. It is important that the coordinator be a person who is acquainted with the community and who has the reputation of being able to work well with other community members. Further, he/she should be involved in the health

self-study from an early stage of the action process. (In Alberta, a P.S.S. director, a senior employee of the local health unit, or any other person having the respect of the sponsoring set and having had some experience in community organization, might be the best person to fulfil the demanding role of community health self-study coordinator). A person serving as the coordinator must have a personal belief in the feasibility and importance of the self-study.

7) active and able leadership.

8) some minimum level of commitment to the value of local cooperation and coordination between agencies and other organizations. If there is no voluntary commitment to the ideals of cooperation and coordination of effort, it will be difficult to conduct a community health self-study.

9) planning the different phases of the health self-study. Setting flexible target dates for the completion of certain aspects of the self-study and placing the activities needed to be carried out in a manageable order, will contribute to the success of the action.

A. 8 General Comments about Community Health Self-Study

Participation in a community health self-study requires a personal involvement which exceeds the ordinary job requirements of the individual. Members of JPCs are likely to have become involved in the JPCs for various reasons. For example, some may realize the potential personal benefits while others may recognize the benefits for the community as a whole.

Although the primary purpose of a Community Health Self-Study is to provide a sounder basis for planning the delivery of health care in the community, there are a number of "spin-offs" that are equally as important. As noted earlier the fact that participating members often become more knowledgeable about their community is one of the benefits of conducting a Community Health Self-Study. Another benefit is that it provides an assessment of a given community's position at a given point in time. (i.e., the study provides baseline data gainst which later assessments of the community may be compared. For example, changes in health needs and associated demands for changes in the health services delivery may be more easily quantified.)

Not only will the data generated by a community health self-study be of use to the health care agencies of the community, but other individuals, agencies, and organizations involved in the provision of services will likely find much of the community background data of value in attaining their own objectives. The leadership potential of the community will also be strengthened when a community health self-study is conducted. Further, participation contributes to a greater awareness of the various factors of community and individual life which relates to the health status of the community. A last observation is that broadly based participation in a community health self-study ensures some actualization of the ideal of consumer participation in health care planning and delivery. Increased community awareness of the availability of the health resources of the community is also a likely result.

A. 9 Who Should be Involved in a Community Health Self-Study?

Since a comprehensive study of the health needs and resources of the hospital district involves the study of all types of health needs and resources, it is important that the maximum number of organizations providing health care and related services are represented on the JPC steering committee, (and on the other committees that will likely be set up to conduct the health self-study). Ideally, the following groups should be represented:

> the boards of the general hospital(s), the auxiliary hospital(s) and nursing home(s); administrative personnel from these institutions; medical clinics; dental clinics; the Regional Office of A.S.S. & C.H., the Public Health Unit; the P.S.S. Board; voluntary health organizations, school counselling services; AADAC; Services for the Handicapped; Alberta Mental Health Services; business organizations; voluntary organizations; the clergy; recreation departments; day care boards; student council(s) of the high school(s); educators; and the local mass media.

A. 10 Activities Involved in a Community Health Self-Study

Once a JPC decides to conduct a community self-study, their next task is to decide on the scope of the study. The JPC might decide to study within a given year only certain health care aspects, (e.g., the organization of health care services within the hospital district), or it might decide to study all the health care areas covered by the ACHSSO. The decision regarding the scope of the study will influence which individuals will be involved in the study, and the number of participants required. The number of participants available will effect the feasibility of studying all aspects of the community's health and health care services.

One possible source of membership for the community health self-study is the high school population; (particularly, students enrolled in social studies classes). If the cooperation of the teacher(s) of social studies, or health subject, can be solicited, students enrolled in such classes could be provided with an opportunity to participate directly in one method of doing social research. The students would add to their own knowledge and that of others, and through their participation contribute to "the common good" of the community. High school students would be an excellent group to ask for help in completing the various sections of Part I of the ACHSSO.

It might be beneficial for the JPC to set up a number of committees which would complete various sections of the ACHSSO. For example, the section concerned with environmental health (in Part II of the Guide) might best be answered by a committee consisting of individuals having an interest in this area (e.g. a public health inspector, or persons involved in industrial health programs within the various industries of the hospital district.) Further, a committee consisting of employees of AADAC, Services for the Handicapped, Alberta Mental Health Services; school counsellors, and members of voluntary organizations (e.g. Alcoholics Anonymous and the C.M.H.A.) might investigate the areas pertaining to mental health, alcoholism, mental retardation, and the physically handicapped.

It is desirable to attempt to solicit the support of the local mass media for the community health self-study. This would be of particular importance if the JPC decided to conduct a survey of health attitudes and opinions in the hospital district. Ideally, the study group's coordinator would handle news releases. The coordinator should be aware of the news items which have been released, and of what media appearances have been made by members of the various committees. In addition, a public relations committee might be formed.

In a community health self-study, it is likely that the various committees will complete their studies at different times. Documentation of the findings will thus often proceed in stages. Documenting the findings of the study can be done by using the format provided by the right-hand pages of ACHSSO. These completed right-hand pages can, in turn, be used to form the basis of separate reports.

A. 10 Notes on Census Information

Most countries in the world, at regular intervals, take a complete inventory of their population. This is called a census. In Canada, a census is taken very ten years (the decennial census) to determine representation-by-population in the Federal House of Commons. Of course, many other important information needs are also satisfied by a census, such as those of federal, provincial, and municipal governments, as well as those of business, and industry, and private agencies and organizations. Census data provide information about the characteristics of social and economic life in Canada at a specific point in time and they aid in planning and decision-making. The census is taken by Statistics Canada.

Statistics Canada also takes a five yearly census (quinquennial census). The last decennial census was held in 1971 and the last quinquennial census was held in 1976. The latter census gathered data only on the following population characteristics: age, sex, relationship to head of household, marital status; and (new in 1976) certain education, occupation and income data.

The decennial census provides massive amounts of data of which the following are of particular interest to a community health study:

1) geographical distribution of the population are provided for provinces, electoral districts, census divisions, municipal subdivisions and rural/urban areas. Historical tables on population growth and reference maps are also included. This information is contained in a set of reports (census bulletins) having the census catalogue numbers of 92-701 to 92-712 for 1971 census data.

2) general characteristics of the population are classified by sex, age, marital status, schooling, internal migration and ethnicity.

3) households: data on size and composition of households; cross-classifications by characteristics of head.

4) families: data on size and composition of families, cross-classification by characteristics of head.

5) housing characteristics: data on rooms per dwelling and persons per room, etc.

6) labour force and individual income: data on distribution of total labour force and wage and salary income, etc.

7) labour force and distribution of occupations.

8) labour force and distribution by industries.

9) income of individuals: total and employment income and cross-classifications by sex, age, and schooling.

Statistics Canada publishes a census catalogue which details what kinds of census data are available and in what format. This catalogue is available, without cost, upon request from the Regional Office of Statistics Canada in Edmonton (9th floor, Baker Center Building, 10025 - 106th Street, Edmonton). The census catalogue is an important resource to the JPC because it indicates which types of census data are available in printed format, and which are available on computer print-outs and microfilm.

The basic statistical result of the 1971 census and earlier decennial censusses are issued by Statistics Canada in the form of several series of bulletins. There are a number of important resources in the Province from which assistance in census data gathering may be obtained. These resources include: the Edmonton Office of Statistics Canada; the Legislative Library; the A.H.S.C.; the Population Research Laboratory, Department of Sociology, University of Alberta, Edmonton; and the A.S.S. & C.H. library, Administration Building, Edmonton.

Data related to the demographic and socio-economic characteristics referred to in the ACHSSO are available in printed form (in the census bulletin series) for counties, and communities having a population of 5,000 or more, or 10,000 or more. Certain census bulletins provide data for cities, towns and villages as small as 1,000 population. For smaller communities and segments of counties, it may be necessary to use data available per census "enumeration area" (EA's). By aggregating EA's it is possible to delineate particular geographic areas (such as a segment of a county) and obtain demographic and socio-economic data otherwise unavailable for those areas.

An EA is the territory covered by one enumerator when taking a census. Data reported by an EA is available in the form of computer print-outs (e.g. via the Population Research Laboratory or the Alberta

Bureau of Statistics). Since using EA data for large areas is a time-consuming task, the JPC should assure itself that published data (e.g. in the census bulletin series) are not available for all or part of the hospital district before using EA data exclusively.

One procedure for identifying EA's in a hospital district is to: 1) obtain a map showing EA boundaries by federal electoral district (ED); 2) trace the boundaries of the hospital district on the ED map; 3) record the number of the EA's within the area of the map covered by the hospital district; 4) obtain the assistance of the Population Research Laboratory, or the Alberta Bureau of Statistics, in collecting the data on the EA's.

Another procedure for identifying the EA's in the hospital district is to use the 1971 Census "Official List: Western Provinces" published by Statistics Canada which permits census users to re-group geographic units such as EA's according to their needs. The Official List outlines the EA's and census sub-divisions for each of the fifteen census divisions in Alberta. (To determine study areas within Edmonton and Calgary, it is suggested that the city maps prepared by the Population Research Laboratory be used to determine the EA and ED numbers).

A helpful guide to using EA data is the "Guide for Users of Enumeration Area Print-Out Data from the Censuses on Population and Housing, 1961 and 1966", by C.S. Lyon, Department of Sociology, University of Alberta, Edmonton, 1969.

A. 11 Sources of Information

When documenting the results of the community health self-study it is important that the source(s) of information for the items or questions in the ACHSSO be identified. Identification of information sources will facilitate making comparisons with studies undertaken at a later date. The ACHSSO identifies potential sources of information for some of the questions asked in the column "Introductory Comments and Sources of Information".

The maps provided in the Appendix section of the ACHSSO will enable the JPC to identify in which Census District(s) the hospital district is located; the latitudes between which the hospital district is located; which health units provide services in the area covered by the hospital district; and in which region of the Department of Business Development and Tourism the hospital district is located.

To begin the study of the hospital district it is important to determine what type of socio-geographic unit it is. From the map showing the location of hospital districts in Alberta, it may be seen which county(ies) (or M.D., I.D., or special area) are covered by the hospital district under study. Alberta is divided into 30 counties, 18 municipal districts, 24 improvement districts, and three special areas. Information about the total population living in Alberta's 10 cities, 101 towns, 168 villages (called Incorporated Municipalities), and the number of people living in the rural areas of the counties, improvement districts and special areas for the year ending December 1975, may be found in the report "Municipal Statistics: Including Improvement Districts and the Special Areas".*

Since people often cross county boundaries to reach commercial or trade centers, the general nature and setting of the community will only be fully understood in the context of the region in which the community is located. The regions in Alberta referred to in the ACHSSO are the ten regions of the Department of Business Development and Tourism.

The general approach to community health study used in the ACHSSO is to proceed from an examination of the regional setting to an examination of the hospital district, the county(ies) within the hospital district, and the communities within the county(ies).

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*Report published by the Department of Municipal Affairs, Edmonton: Queen's Printer, 1976.

SECTION B: Introduction to the Region

Introductory Comments and Sources of Information

B. 1 Location of the Hospital District

Using the March, 1975, map showing the ten regions of the Department of Business Development and Tourism, the JPC will be able to identify in which region the hospital district is located. Because different government departments, organizations, and agencies provide services on a regional basis, many of these groups have divided the Province into regions suiting their own particular needs. Studying the community background of the hospital district will be facilitated if the JPC identifies with which other regional boundaries the boundaries of the hospital district overlap. This will allow ready identification of which specific regional branches, divisions, or offices of government departments provide services within the hospital district. Maps showing the regional boundaries of: (1) census divisions; (2) health units and city health departments of the ASS&CH; (3) hospital districts; (4) Alberta Mental Health Services (of ASS&CH); (5) Alberta Alcoholism and Drug Abuse Commission; (6) Services of the Handicapped (of ASS&CH) might be consulted.

Analysis and Interpretation

Location:

Identify the location of the hospital district within the region. Note within which latitudes the hospital district is located, and which counties are wholely or partly covered by the hospital district.

SECTION B: Introduction to the Region

Local Situation

B. 1 Location:

The ______________________ Hospital District is located in the ____ __________________ Region of Alberta. Its boundaries fall between the _______ and ______ latitudes. It covers the following counties (or M.D.'s or I.D.'s)

County of ______________
County of ______________
County of ______________
County of ______________

(Specify whether the County(ies) is (are) wholly, or in part, covered by the hospital district).

SECTION C: Introduction to the Hospital District

Introductory Comments and Sources of Information

The social, economic and health conditions in a region are influenced by the natural and man-made characteristics of the area, such as: size, location, topography, natural resources, transportation, population, economy, etc.

C. 1 Principal Geographic Features

Characteristics of the topography or terrain often affect the location of communities, and may allow for or limit expansion. In many of the hospital districts in Alberta, the factor of topography is of secondary importance to the composition or quality of the soil. Within most hospital districts there will be at least one community (likely the county seat) for which the Department of Business, Development and Tourism has prepared a "Community Profile" brochure, which contains information about maximum and minimum temperatures, annual rainfall, etc.

Analysis and Interpretation

Topography or terrain: Has the topography of the land affected the location of the communities in the hospital district? Does it limit expansion of the communities?

Soil: Either in this section, or in the section on demographic characteristics of the county, note whether the quality of the soils varies within the hospital district, and if so, discuss where the better and poorer soils are.

Is the soil everywhere suitable for residential development with respect to sewer and septic tank construction?

Water: Are there any lakes and/or rivers in the hospital district? Are they scenic assets? Do they have recreational usage? Did they in the past?

SECTION C: Introduction to the Hospital District

Local Situation

C. 1 Principal Geographic Features:

Climate: Average summer maximum temperature _____deg. C.
Average summer minimum temperature _____deg. C.
Average winter maximum temperature _____deg. C.
Average winter minimum temperature _____deg. C.

Average rainfall _____inches per year
Average snowfall _____inches per year
Total precipitation _____ inches per year
Frost free days in 19__ ______

a. Are droughts a problem in the Hospital District?
b. Is flooding a problem in the Hospital District?

Topography or Terrain:

Soil:

Water:

Introductory Comments and Sources of Information

C. 2 Natural Resources

Knowledge of the major natural resources of an area provides for insights into the characteristics of the region.

C. 3 Tourism

In many regions, or parts of regions, of Alberta tourism is an important industry. Knowledge of the tourist industry in the hospital district is important since the influx of substantial numbers of tourists often makes additional demands on the health care services being provided.

In some parts of the Province (e.g., in the National Parks), tourism creates a substantial influx of people during most months of the year. In other parts, tourism makes only seasonal extra demands on health care services for about three of four months per year.

C. 4 Communication Systems

Communication systems are important to health and health care delivery. The JPC should document the existence or absence of T.V.; the radio stations located within the hospital district, or outside the hospital district but having a significant audience in it; the newspapers published within the hospital district, or outside, but having significant circulation within it. How often these newspapers are published might also be important.

Analysis and Interpretation

C. 2 Natural Resources:

Discuss what the major natural resources are within the hospital district, and within the surrounding hospital districts (the latter only if there is a relationship between these resources and the health and health care of the hospital district). Comment on whether the resources are of major or minor significance to the economy of the hospital district.

C. 3 Tourism:

What are the characteristics of tourism within the hospital district? Are the tourists chiefly "tourists in transit", or tourists seeking "resort" enjoyment in the area? Does tourism have a seasonal impact on the hospital district? Does the influx of tourists pose any health and health care problems?

C. 4 Communication Systems:

Is quantity and quality of health coverage generally good or bad? Do any of the mass media identified take leadership in improving aspects of health? What aspects? Are they successful? Are they in any way involved in the study? Could they assist in interpreting and publishing the results of the study? What appear to be some of the most successful ways of "promoting" community social, civic, and health programs? List the names and sources of health columns or health programs appearing periodically or routinely in the newspapers, on radio, or television.

Local Situation

C. 2 Natural Resources:

(discuss) (i.e. sand/gravel; natural gas, etc.)
Commercial deposits are available for —

Agricultural and horticultural products produced are --

C. 3 Tourism:
(discuss)

C. 4 Communication Systems:

Introductory Comments and Sources of Information

C. 5 Major Transportation Routes

Few health services are now delivered at the homes of the residents of the hospital district. There is often a direct relationship between transportation and utilization of health services. Therefore, transportation is an important aspect to consider when assessing health needs and resources, and when planning for comprehensive integrated health services.

Though most residents will be aware of where the primary and secondary highways of the hospital district are located, and with which communities they connect, it is unlikely that they will be accustomed to think in terms of "hospital routes", "mental health routes", "social services routes", "health unit routes". With the aid of road maps, it may be fruitful to determine which of the communities in the hospital district are not served by public transportation to the center (community) where most health and social services are provided.

Aspects to be considered regarding transportation routes are: whether they are open all year round; whether all communities within the hospital district are linked by bus service, and, whether there is a frequent service; which highways are the most important routes for ambulance transportation to and from the hospital facilities inside or outside the hospital district.

An analysis of the kinds of transportation and the transportation routes within and between communities provides health and allied workers with important information about the health and social services shopping patterns of the residents of the hospital district.

Analysis and Interpretation

Describe the major transportation routes especially as they influence the delivery of health services.

(a) Air Transportation: Is there an airline service within the hospital district? Is it used by health professionals from larger centers who provide services within the hospital district? How regular is the service? Is it used for air ambulance service?

(b) Water Transportation: If in existence, is it of relevance to health care?

(c) Railroad Transportation: Is this mode of transportation used for passenger service? Is it used by many people living within the hospital district?

(d) Road Transportation: Are the roads (primary and secondary highways) within the hospital district maintained so as to allow ready access to the hospitals and other health services throughout the year? Identify the problem areas.

Has there been a significant change in the transportation pattern within the hospital district during the past five years? If so, is this due to: new roads; improvement of highway(s); rapid expansion of community(ies) within the hospital district or within easy access beyond its boundaries?

Local Situation

C. 5 Major Transportation Routes:

(a) Air Transportation:

Nearest commercial airport(s):
Number and lengths of runways:
Nearest private airport to hospital: (Identify which hospital(s))

All weather facilities: Yes____ No____
Air passenger services:
Plane servicing: Yes____ No____

(b) Water Transportation: Yes____ No____ (If "yes" provide details)

(c) Railroad Transportation:

Name of Railway:
Frequency of service:
Pick-up and delivery service: Yes____ No____
Passenger service:

(d) Road Transportation:

Truck Transport

Names of local trucking firms servicing the area:

Terminal facilities:

Overnight delivery to:

Passenger Bus Transport

Which communities in the Hospital District are served by regular bus service?

For each of the communities served, what are the frequency and departure times?

SECTION D: Demographic Data on the Hospital District

Introductory Comments and Sources of Information

It is suggested that, throughout Sections D, E, and F of the ACHSSO, the JPC should obtain 1971 and 1976 census data, and any other available information.

D. 1 Size

The area of the hospital district and its demographic characteristics are important factors in determining health needs, and in planning services in the hospital district.

D. 2 Hospital District Boundaries and Demographic Data Gathering

The boundaries of most hospitals encompass at least one county. When the hospital district also covers a portion of another county, it is necessary to estimate what proportion of the county's demographic data applies to the portion in question. Accuracy will be improved if the JPC estimates the number of residents living in the rural part of the county's portion in question, and if the villages and hamlets in that portion are identified. The population size of the communities should be determined.

D. 3 Sources of Statistical Data

1) County annual reports (available from county office).
2) The report "Municipal Statistics" (available from county office or Department of Municipal Affairs, Jarvis Building, Edmonton).
3) Statistics Canada (901-10025-106th St., Edmonton)
4) Statistics Alberta (480 Terrace Building, Edmonton)
5) Legislative Library (Legislative Building, Edmonton)
6) Alberta Hospital Services Commission (Petroleum Plaza Building, North Tower, Edmonton)
7) Population Research Laboratory, Department of Sociology, University of Alberta, Edmonton.
8) Library, Department of Social Services and Community Health (Administrative Building, 98 Ave/108 St., Edmonton)

Analysis and Interpretation

Does the geographic and/or regional location of the hospital district present any advantages or disadvantages for health?
What was the number of people per square mile in the hospital district in 19__? (Give latest year for which figures are available)
The population file sheets on each hospital district kept by the A.H.S.C. show the totals of the population living in the rural areas of the county(ies) covered by the hospital district, and the totals of the population living in the incorporated municipalities within the hospital district.
Under conclusions about size, density, and distribution, the JPC might discuss whether there has been: an increase or decrease in the total population; a substantial rural to urban shift; a substantial increase in population in the municipalities; a substantial increase in the number of "suitcase farms" or acreages.

SECTION D: Demographic Data on the Hospital District

Local Situation

D. 1 Size:

Area of Hospital District ______________ sq. miles or ____________ acres

D. 2 Demographic Data Gathering:

Density

There were _________ people per sq. mile in the hospital district in 19__.

Distribution: (This information may be taken from the population file sheet which the A.H.S.C. keeps on the hospital district.)

Conclusions about size, density, and distribution of the population of the hospital district:*

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*It might be easier to write these conclusions after the sections on county and community have been completed.

SECTION E: Demographic Data on the County

Introductory Comments and Sources of Information

E. 1 Size

When the hospital district's boundaries are not coterminous with those of the county(ies) covered, it is suggested that the JPC first gather the data suggested relating to the county(ies) totally covered by the hospital district. Thus, if half a county falls within the boundaries of the hospital district it may be most economical to first obtain the demographic data on the entire county and then to estimate which proportion of the data applies to the half of the county falling within the hospital district's boundaries.

When the hospital district covers only a relatively small rural area of a county, it is often not worthwhile to gather all the demographic data suggested for this area. In such situations it would suffice to note that the hospital district also takes in _____ population (actual or estimated figure) living in the county of _______________.

E. 2 Population Data: General Comments

Many municipalities in Alberta conduct an annual census during non-cens s years to update the count of their population. These annual censuses tend to be slightly overestimated. The results of these censuses are collected and published by the Inspection Branch, Department of Municipal Affairs.

In Alberta, the population increased by 22.2% between 1961 and 1971, reaching a total of 1,627,874. The number and percentages of the population falling within the various age groupings can be obtained from census data. Percentages can be plotted on tables and histograms. As there is a strong relationship between patterns of ill health and age, it is important to have up-to-date information about the community's age structure. When possible, growth projection figures for the county's population should be obtained. (The Department of Municipal Affairs is a possible source).

Although the rural to urban shift continues during the seventies, there are some rural areas in Alberta (particularly those within a fifty mile radius of Edmonton and Calgary) which have seen a reversal in this shift. The provincial government is actively promoting the policy of stimulating the growth of smaller rural centers and is discouraging the growth of the metropolitan areas.

Analysis and Interpretation

Has there been a significant rural to urban shift in the county during the past ten years?
Is this trend expected to continue?

SECTION E: Demographic Data on the County

Local Situation

E. 1 Size:

The area of the county of ____________________ is __________ sq. miles

Total land area __________acres
Total water area __________acres

Proximity to large urban centers: Using the county seat as the point of departure,
area(s) having a population of:

a. 100,000+ _______________
b. 25,000+ _______________
c. 10,000+ _______________
d. 5,000+ _______________

E. 2 County Population Data:

Complete the following table by indicating the number and percentage of the county population in terms of rural and urban for the year 1971 and the latest year:

	URBAN*		RURAL*		TOTAL
AREA	Number	%	Number	%	Number
County					
Alberta					
Canada					

*For meaning of urban and rural see the census definitions given below.

Rural municipalities include: 1) all part of incorporated rural municipalities, unorganized territory and Indian Reserves having a population density of less than 1,000 per square mile; 2) incorporated cities, towns, villages, and hamlets with populations less than 1,000.

Urban municipalities include: 1) incorporated municipalities with a population of 1,000 or over and having the legal status of city, town or village; 2) incorporated places of 1,000 population or over having a population density of at least 1,000 per square mile; 3) the urbanized fringe of 1) or 2) if it has a minimum population of 1,000 and a density of at least 1,000 per square mile.

Introductory Comments and Sources of Information

E. 3 Population Change

Population change is due to migration (in or out) and to natural increase (birth and death rate difference). The net migration rate may be determined by subtracting the natural increase rate figure from the total change figure. The Vital Statistics Bureau, Alberta Social Services and Community Health, annually provides birth and death information by census division. The rate of natural increase may be determined by calculating the:

$$\frac{\text{Excess of births over deaths which occurred among the population of a given geographic area during a particular year}}{\text{Mid-year total population of the given geographic area during the same year}} \times 1{,}000$$

Gain or loss in the population of the county seat during the past ten years provides an indication of the socio-economic conditions of the county. It is important to learn about the extent of gain or loss, and also to assess what factors give rise to the gain or loss. Possible factors of loss of population include: youths of school-leaving age leaving the community; weakening of the industrial base of the community; escalating costs of houses; and lack of services.

E. 4 Population Composition: Age Structure

The composition of the population by age, sex, and ethnic background gives important clues to health conditions. It is generally accepted that, as a minimum, the population breakdown should include age, sex, and such factors as educational attainment, household and family, education, and ethnic background. Other socio-economic factors such as income and occupation should also be considered in health care planning. In particular, the factors of age and sex are fundamental demographic material for an understanding of the prevalence of disease. In the main, the community's age structure depends on birth rates and not on death rates. In a community with a high proportion of older people, more health services will be required, particularly extended care facilities and home care services. A rise in the number of births calls for additional maternal and child health services.

Analysis and Interpretation

E. 3 Population Change

The JPC might compare the population change within the county with that of other counties in the region, and with that of the Province.

Compare the population change of the county seat to that of the county and of the Province.

In addition to change, the county population may be examined for size, density, distribution, and composition.

Examination of the ages of people moving in or out of the county provides important information about how the county is changing.

Introductory Comments and Sources of Information

Analysis and Interpretation (Cont.)

E. 4 Population Composition: Age Structure

From the latest census data, complete the tables on the following pages which indicate the age composition of the county population for 1971 (and later years, if possible).
Are there large fluctuations in the birth rate?

Local Situation

E. 3 Population Change in the County, 1961-1971: (Repeat for 1971-19__ (latest year)

(a) Percent Population Gain-Loss and Rates of Migration and Natural Increase*

Area	Population		Total Change	Net Migration	Natural Increase
	1961	1971			
County					
Hospital Dist.					
Alberta					

Comments:

(b) Percent of gain and loss in urban and rural population, 1961-1971, 1971-19__ (latest year)

AREA	URBAN 1961-1971	RURAL 1961-1971	URBAN 1971-19__	RURAL 1971-19__
County				
Alberta				
Canada				

Comments on urban and rural change:

---

*For the smaller communities in the county it may be difficult to determine the rates of net migration and natural increase.

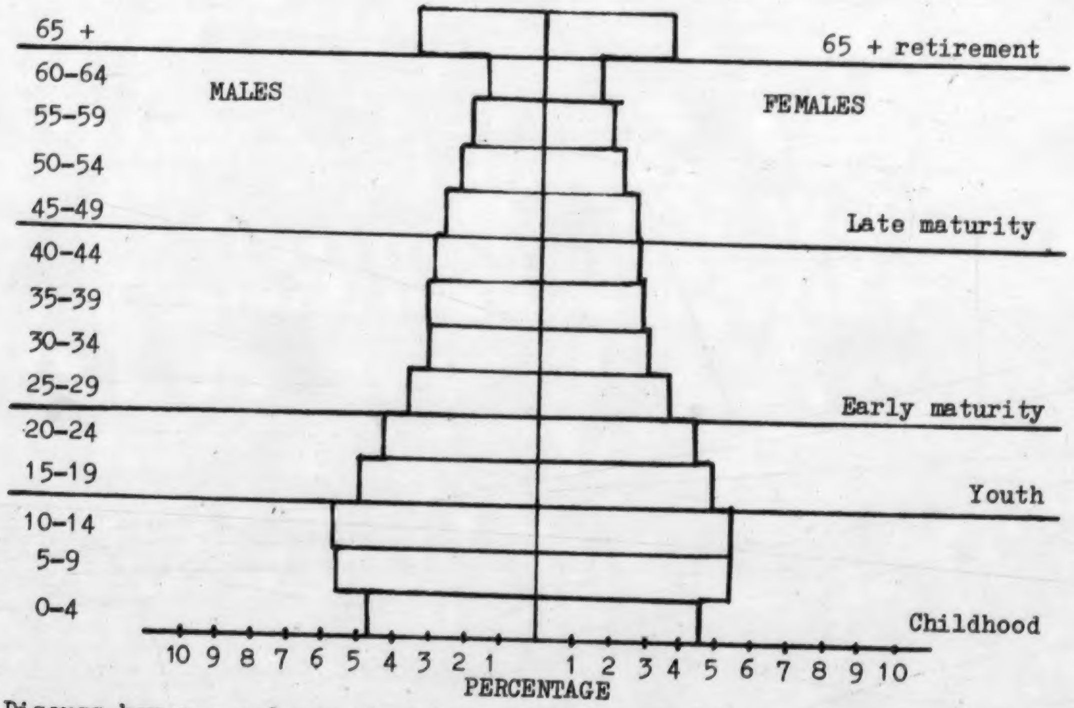
Local Situation

E. 4 Age Structure of County Population and percentage change of numbers

(a) Age structure of county population, 1971 and 19__ (latest year), and percentage change of numbers in specified age groups, 1971-19__ (latest year).

Age	1971 County		1971 Alberta		19__ County		19__ Alberta		% change	
	Number	%	Number	%	Number	%	Number	%	County	Alberta
Under 15										
15 - 19										
20 - 24										
25 - 34										
35 - 44										
45 - 54										
55 - 64										
65 - 69										
70+										

(b) The Histogram below portrays the age and sex distribution for Alberta as a whole in 1971. Superimpose the County age and sex structure using the percentages of above table:



Discuss how age and sex structure of the county differs from that of the Province.

Introductory Comments and Sources of Information

E. 5 Sex Ratio

The sex ratio of a population is the number of males per 100 females

E. 6 Dependency Ratio

This is the percent of the population in the production category divided by the percent in the non-productive category: (It is otherwise defined as the proportion of the total population under 18 years of age and 65 or older)

E. 7 Education

Information about enrolments in the county public school system may be obtained from the annual reports of the superintendent of schools. Data from annual reports will allow identification of school enrolments over the years, (e.g., reflect the effects of the postwar "baby boom").

It is important to note the location of schools within the county, what type they are, what the teacher-pupil ratio is for each school, whether there is a school counsellor at the school, and what health-related educational courses are offered. Similar information should be obtained from separate schools, or special schools within the county.

Educational levels are related to health concerns and to utilization of health services. It is therefore considered wise to gear the health education activities to the educational level of the recipient. Individuals with four years or less of formal schooling are usually designated as technically or "functionally illiterate" since they generally have difficulty in reading and understanding many forms of communication.

Analysis and Interpretation

Since 1945, what was the peak year for school enrolment?
Are considerable changes expected in the numbers of school enrolment within the next few years? In all schools?

E. 5 Sex Ratio:

The sex ratio of the county in 1971 was _____ compared with ______ for Alberta. The sex ratio of the county in 19__ (latest year) was ______ compared with ______ for Alberta.

Does the sex ratio of the county's population present or suggest any special health problems of some magnitude? (comment)

Special Groups:

Are there any special population groups in the county such as migrants having language problems, Hutterite colony(ies), college students, etc.?
Yes_____ No_____
If yes, discuss whether these groups are likely have have special health problems:

E. 6 Dependency Ratio:

What is the dependency ratio in the county in 19__? The D.R. is _____
What was the dependency ratio in the county in 1971? The D.R. was _____
Comments:

E. 7 Education:

(a) School Enrolment:

Total school enrolment in the public schools of the county for the years following 1945: (repeat for separate schools, private schools)

1946 ________
1947 ________
1948 ________
1949 ________
1950 ________
1951 ________
1952 ________
etc.

Comments:

(b) Level of Schooling:

From the most recent census data available (specify year), the County's population aged 15 and over by level of schooling for males and females was:

Level of Schooling	Males		Females	
	Number	%	Number	%
Less than Grade 5				
Grades 5 - 8				
Grades 9 - 10				
Grades 11 - 13				
- With Other Post Secondary				
- Without Other Post Secondary				
Some University				
University Degree				

Compare with other counties in the hospital district, or neighbouring counties.
Comment:

Introductory Comments and Sources of Information

E. 8 Households

A household consists of all individuals occupying a given dwelling. It includes all members of the family(ies), lodgers and their families, employees and their families, and other members of the household. In 1971, there were 464,943 households in Alberta, an increase of 32.9% over the 1961 total. The average number of persons per household was 3.7 in 1961; 3.6 in 1966 and 3.4 in 1971.

E. 9 Families

A family consists of a husband and wife (with or without children who have never been married, regardless of age) or a parent with one or more children never married living in the same dwelling. A family may consist also of a man or woman living with a guardianship child or ward under 21 for whom no pay is received. The "Head of the Family" is the husband in a husband-wife family, or the parent in a one-parent family. Non-family persons include: persons living alone and persons not related to each other living in a household.

Family characteristics, such as the total number of families, age and sex of the head of the family, average number of children per family, and the percent of change in these characteristics, are considered to be health-relevant information about the county. The average number of persons and children per family in the county may be compared with those for the Province, which were:

Year	Average # of persons	Average # of children
1961	3.8	1.8
1966	3.9	1.9
1971	3.8	1.8

Between 1961 and 1971, the total number of families in Alberta increased by 25%, from 305,671 to 382,112.

Analysis and Interpretation

Households: Has there been an increase or decrease in the average number of persons per household in the county between 1961 and 1971, and between 1971 and 1976?

Families: The data obtained about families in the county may be compared with the average number of persons per family.

E. 7 Education (cont.):

(c) Functionally illiterate persons:

The percentage of people in the county who are "functionally illiterate" is _____ percent, compared to the Alberta average of _____ percent. The health implications suggested by the county percentage are:
(Comment)

E. 8 Households:

The total number of households in the county was _________ in 1971 (as per census information), with an average of _____ persons per household, compared with a provincial average of _____ persons per household.

There was an increase of _____
From 1961 to 1971 the number of households in the county increased by _____ percent, compared to 32.9 percent in Alberta.

Comments:

E. 9 Families:

In 1971 the total number of families living in the county was _________, and the average number of persons per family was ______. (Repeat for latest on which information is available.)

Non-families: Indicate the number of non-family persons living in the county:

Comments:

Introductory Comments and Sources of Information

E. 10 Income

Attempts to establish comprehensive and accessible health services in the community should be guided by an analysis not only of the health resources available (manpower, money, and material), but also by the economic situation and the general purchasing power of individuals and families in the county. In families with limited income, health care must compete against other desired aspects of a given "standard of living". Communities characterized by extensive poverty present a higher degree of vulnerability to health impairment. Multi-problem families present another high-risk group.

Under the Alberta Health Care Insurance Plan most health services are free of charge. However, certain services are not covered by the A.H.C.I.C. (e.g., dental services, some pharmaceutical products, optical products). It thus becomes meaningful to know about the income levels of families and unrelated individuals; particularly of those whose income is below the "poverty line" (as defined by the Economic Council of Canada) or below the provincial average.

E. 11 Public Assistance

Most of the public assistance programs in Alberta are administered by district offices of A.S.S. & C.H. The monthly, trimonthly, and annual reports of the regional office of A.S.S. & C.H. which provide the social public) assistance programs will reveal the extent tf the public assistance needs in the county. (These reports -- also called "caseload evaluation sheets" -- reveal the types of assistance provided, the number of cases receiving each type of assistance, and the number of manhours involved in the administration of these types of assistance.)

Analysis and Interpretation

E. 10 Income:

Family income refers to the sum of all income received by all members of the family 15 years and over, from all sources.
Are many families in the county considered to be living below the poverty line?
Pharmacists may be asked if there are many people who cannot afford to pay for medical prescriptions, or who have to pay by instalments.

E. 11 Public Assistance:

Are there any groups in the county receiving public assistance directly through a Federal Government Department (e.g., the Department of Indian Affairs)?
Is the need for public assistance expected to increase, decrease, fluctuate considerably, or remain the same within the next few years?
What changes have taken place in the public assistance programs in the county? To what extent are these programs tied in with health and medical problems?
How does the county compare with neighboring counties in terms of public assistance provided?

E. 10 Income:

What was/is the average family income of the county population during the years:

County -- 1961 ________	Alberta — 1961 ________
County -- 1966 ________	Alberta -- 1966 ________
County — 1971 ________	Alberta — 1971 ________
County -- 197_ ________	Alberta -- 197_ ________
County -- 19__ ________	Alberta -- 19__ ________

The average family income of the county population compared to the Province suggests:

If possible, ascertain or estimate what number and/or percentage of families and unrelated individuals in the county live below the "poverty line", as defined by the Economic Council of Canada:

E. 11 Public Assistance:

The level of financial assistance (provincial, federal, and municipal): Information from the regional office of A.S.S. & C.H. indicates that the level of financial assistance in the county is: (repeat for Federal and Municipal assistance programs)

Introductory Comments and Sources of Information

E. 12 Ethnic distribution

From the census bulletins on ethnic background, the JPC will be able to obtain information about the ethnic composition of the census district in which the hospital district is located. The census catalogue will tell the JPC whether data on ethnic background is available for the county only, or also for the large communities in the county.

Ethnic background may be an important factor to consider in a community health study. Many older immigrants in Alberta have only learned marginal English, and this may pose problems in terms of following medical orders, and self-identification of symptoms.

E. 13 Working Population and Employment Data

The number of people in the work force, their employment rate, and the distribution of the working population by industry and occupation are economic factors having implications for many areas of health care.

Businesses are of many types and can be classified into major industrial categories as defined by the Census of Canada compiling an inventory of the businesses located within the county is one means of gathering information about the county's industrial base. If such a task is undertaken, it might be useful to indicate the number of workers employed in each industrial category. The customers of a community's businesses and industry are drawn from both inside and outside the county. The area from which customers are drawn is known as its "trading area".

If the JPC wants to study more intensively the industrial aspects of the county or hospital district it might ascertain if the Research Planning Section and the Provincial Planning Branch, Department of Municipal Affairs, have completed a regional study report on the area in which the county is located.

Analysis and Interpretation

E. 12 Ethnic Distribution:

Do language barriers impede communication with regard to health problems?
Do cultural barriers inhibit or facilitate delivery or utility of health services?
Are any areas predominantly composed of one particular ethnic group? If so, what, if any, are the implications for health-related problems and communications?

E. 13 Employment:

Has there been a substantial shift in the county's economy in recent years? (for example, from a heavy reliance on farming to an increasing dependence on manufacturing and commerce) How is this shift reflected in the work force?
As measured by the number of people working in the agriculture industry, either as farmer-owner or employee, what has been the percentage of decline?

Introductory Comments and Sources of Information

Analysis and Interpretation (Cont.)

What are the major employment, industrial, and occupational aspects of the county and what health problems does this economic situation pose? The percentage or number of unemployed may be examined. Is unemployment high compared with other counties in the region? Compared with the Province? What are the main causes of either temporary and/or permanent unemployment?

Is anything being done to attract industry to the county? If "yes", elaborate.

E. 12 Ethnic Background:

Ethnic groups for males and females in 1971: (repeat for latest year possible).

Ethnic Group	Males	Females
British Isles		
French		
Asiatic		
Austrian		
German		
Hungarian		
Italian		
Jewish		
Native Indian and Eskimo		
Netherlands		
Polish		
Russian		
Scandinavian		
Ukrainian		
Other and Unknown		

Examine census data and other source(s) of information (if available), and discuss whether the data suggest any health implications:

E. 13 Working Population and Employment Data:

(a) Labor force by marital status for males and females in the county in 1971 was: (repeat for latest year possible).

Marital Status	Males		Females		Mal. & Fem.
	Number	%	Number	%	Total Number
Single					
Married (incl. separated)					
Widowed or Divorced					

SECTION E: Demographic Data on the County (Cont.)

Local Situation

Working Population and Employment Data (Cont.):

(b) Non-Manufacturing Employment:

Name of Company	No. of Employees	Type of Business

(c) Manufacturing Employment:

Name of Company	No. of Employees	Type of Business

E. 13 Working Population and Employment Data: (Cont.)

(d) Distribution of county labor force by occupation for males and females: (as per 1971 census data or latest information available)

Occupational Category	Males		Females		Male & Fem.
	Number	%	Number	%	Total Number
Managerial, Administrative, and Related Occupations					
Teaching and Related Occupations					
Occupations in Medicine and Health					
Technological, Social, Religious, Artistic, and Related Occupations					
Clerical and Related Occupations					
Sales Occupations					
Service Occupations					
Farming, Horticulture, & Animal Husbandry & Other Primary Occupations					
Machining, Product Fabricating, Assembly and Repair Constr., Trades Occupations					
Transport Equipment Operating Occupations					
Materials Handling, Other Crafts, & Occ's Not Elsewhere Classified					

(e) Employment in the county by industrial category: (as per 1971 census data or latest information available)

Industrial Category	% total employees	total no. employees	% firms in each category
Agriculture			
Forestry			
Fishing & Trasping			
Mines, Quarries & Oilwells			
Manufacturing			
Construction			
Transportation, Communication & Utilities			
Trade			
Community, Business & Personal Service			
Public Administration & Defence			
Finance, Insurance & Real Estate			

Introductory Comments and Sources of Information

E. 14 Agriculture:

It is of value to learn what the total number of farms is in the county, and also the average size and total acreage. Other questions to be considered are: whether the average farm size is decreasing or increasing; what type of farming is predominant; what the produce is (whether farmers diversify); whether there is a decrease in the number of small marginal farms, etc.

The general level of profitability of farming may be examined, and an assessment made as to whether or not the county's agriculture is generally prospering. The District Agriculturalist will be of assistance in obtaining these data.

Analysis and Interpretation

E. 14 Agriculture:

How does farming in the county compare to that of neighbouring counties, and to the Province?
What is the (approx.) average age of the farmers? Is this increasing or decreasing? What specific health problems are associated with a change in age (e.g., increased number of accidents)?
Do many farmers continue to farm beyond retirement age? Are they generally succeeded by sons or other family members? Do they continue to live on the farm after retirement, or do they tend to sell out and move to the town? Which town(s) do retiring farmers tend to gravitate to when retiring? Is this trend changing?
Are there many part-time farmers? Are there many "suitcase" farmers in the county? Are the farms generally well kept, or could it be said that farming in the county is generally deteriorating?
What are the primary crops being grown?

Local Situation

E. 14 Agriculture:

The estimated number of farms in the county was/is, in 1961 -- ______
1966 -- ______
1971 -- ______
197_ -- ______
19__ -- ______

Area	Average size of Farm	Average land value and Buildings per Farm	
County		1971	19__
Alberta		1971	19__
Canada		1971	19__

Comments:

Other information about the status of agriculture in the county:

Introductory Comments and Sources of Information

E. 15 Miscellaneous

Completion of this and the previous Sections of the ACHSSO will have increased the JPCs understanding of the characteristics of their hospital district. It is now possible to focus on the study of the incorporated municipalities of the hospital district.

Cities (if not too large, i.e., over 200,000 population) towns, and villages are convenient geographic, population, social, and political units, which may be examined in greater detail for a variety of purposes. In the ACHSSO, the study of these units has as its focus the health-related aspects of the community. When examining such geographic units as villages, towns, etc., it is important to remember that when such units are studied for the purposes of "community action planning", it is important to think not only in terms of neighbourhoods, residential areas, and social groupings, but also to consider the influence upon community life of the groups and individuals who live at, or beyond, the fringe of the community. Outer-city groups often feel themselves closely connected to the city (or town or village). This situation applies particularly to a community which forms the hub of a farming district. Section F of the ACHSSO provides guidelines for studying the incorporated municipality.

Analysis and Interpretation

E. 15 Miscellaneous:

When examining the rural areas of the county in terms of homogeneous and differing socioeconomic regions, it will be relevant to note the existence of different socioeconomic groups and areas, and to explain where they are in terms of location, and how they differ, i.e., the impact of poor soils on farming conditions in an area.
Discuss in what ways the other communities in the county differ from the county seat.

E. 15 Miscellaneous:

List and locate the other main cities, towns, villages, and hamlets in the county: (insert map of county, if one is available)

Describe the county rural area in terms of homogeneous and different socio-economic regions:

What is the county seat like; is it an urban city, or is it a rural town?

Summarize how the other communities in the county differ from the county seat:

PART I

SECTION F: STUDYING THE COMMUNITIES IN THE HOSPITAL DISTRICT

F. 1 Some Guidelines

1. Introductory Comments and Sources of Information

The focus in Section E was on the study of demographic factors pertaining to the country as a whole. Many of the question items listed in this section should also be asked about the communities located within the hospital district, and they are therefore listed again in Section F.

Section F intends to provide suggestions for gaining an understanding of the structure and dynamics of a city, town, village, or smaller community. The usefulness of the suggestions for studying the community will vary according to the size of the community being studied. The results of a study utilizing Section F will provide a "community profile" which can be of benefit to planners in various areas of community service.

Section F has been designed as a self-contained manual for community study. It is suggested that the JPC make a photocopy of this section for each of the communities in the hospital district. The task of obtaining a given community profile could be assigned to one or more members of the JPC.

The suggestions for studying the community contained in the following pages are drawn from the community study literature, and from the writer's community work experience in a number of small Alberta communities. The ACHSSO assumes that most, if not all, of the JPC members will have some degree of knowledge about the community in which they live or work, and that they are likely to be familiar with other communities in the hospital district. The amount of new knowledge accruing to the individual from his/her participation in the community health self-study will vary, depending on the degree of community knowledge already possessed. It is hoped, however, that even those who have lived and worked in their community for a number of years will derive new knowledge and insights about their community as a result of their participation.

2. Learning about the Physical Aspects of the Community: Assessing Its Strengths and Weaknesses

The following suggestions for studying the physical aspects of the community assume that the person who is about to systematically study a given community is new to the community, but interested to learn as much as possible about it. It is further assumed that the person will want to get to know the community quickly and comprehensively. The following are some suggestions which could be taken in order to learn about the community's physical aspects (to be undertaken by an individual who will be referred to as the "student").

a. A Visit to the Town Office

At the Town Office, the student will, for the cost of two dollars, be able to purchase a map of the town. In addition, he/she may be able to acquire a copy of the town's "Community Profile" brochure (these brochures have been designed for many communities in Alberta by the Regional Services Branch of the Department of Business, Development and Tourism). Third, the student should obtain, if available, a community resources directory. These directories are compiled in many communities, and contain the names of the organizations and agencies providing services in the community (sometimes the directories provide information about the business community).

b. Walking the Town

With the help of the town map it will be meaningful to "walk the town" (although in larger communities, driving may be necessary). The purpose of this activity is for the student to become familiar with the physical structure of the community. The student should mark a code number for every public building on the map at the point where the facility is located. Details of each facility, including the code number assigned, should be recorded on a separate sheet of paper. All public buildings, including churches, schools, community halls, playgrounds, swimming pools, hospitals and nursing homes should be recorded. When observing and assessing the facilities, the student might be guided by the use of the following seven key words:

1) number and size - of the facility, its services or other assets in question; relationship of number and size or capacity to amount of use.

2) age and condition - as related to present and future use.

3) type - of facility and services in relation to need.

4) location - proximity of facilities to people who use them; proximity to transportation; spaciousness and suitability of site; compatible or incompatible surroundings.

5) finance - cost of facility or service to user; cost to producer of providing it; is it healthy or languishing economically?

6) appearance - is the physical facility a well-designed asset to its surroundings?

7) quality - other considerations that make it a good or not-oo-good facility, service or asset.

In addition to recording the location of public facilities and assessing them in terms of the seven key words, the student should take note of the condition and age of the residential dwellings in the community. Other community aspects to be noted are:

1) condition of the roads - paved, gravelled, oiled, etc.

2) industry - where is the community's industry located? Is it in one or more industrial area(s)?

3) commerce - what is the location of the shopping center(s) like? are the shops all or mainly congregated along the main street? are there suburban shopping centers/ are many kinds of merchandise shops represented in the shopping center(s)?

4) offices - with or without the aid of a community resources directory, note the location of the offices of health and social service agencies in the community (i.e. doctors, dentists, the P.S.S. Director, the various government departments).

After plotting the location of the community's public facilities, and noting where the offices of agents providing a health or social service in the community are located, it will then be necessary for the student to obtain specific details about the community in order to learn more about the factors in the community which pertain to health. Before discussing these details a few comments should be made about the approach to be taken by the student who is already familiar with the location of the community's public facilities. This student might simply obtain the town map and plot the required information. However, it might still be useful to walk the town in order to assess the characteristics of the residential areas of the community. New findings are usually generated by looking at one's "familiar" community from a certain perspective (e.g. a health care planning perspective). We normally take our physical surroundings for granted and are unlikely to note that certain neighborhoods may differ in characteristic ways (e.g. in terms of maintenance, size or age of dwellings, fenced or unfenced backyards, etc.).

3. The History of the Community

An understanding of any given community's present status will be enhanced by a knowledge of its past. It is therefore recommended that a brief history of the community be compiled. Such a task could be performed by high school students who could be given academic credit for their contribution to the community's health self-study effort. If there is a library in the community, the librarian will likely know if a history of the community exists. Sources of information for compiling a community history are: the local news media office, the town office, local voluntary organizations, and previous community studies and other reports about the community. A community history should include a brief political history and a history of the development of community voluntary organizations and any projects carried out by these organizations.

Of particular importance for a community health self-study is the compilation of a health history of the community. Such a history would record the development of the health and related services in the community and may provide insights into the development of current health problems, and the difficulties encountered in meeting these problems. A health history should include such events as: the establishment of health care facilities and the individuals involved in the initiation process; under which auspices the facilities were established; whether there has been a change in ownership of these facilities; whether these facilities have been expanded and when; the years when various health services were first being introduced and who delivered them; the occurrence of epidemics, disasters, and other health-related events, such as the establishment of a public water supply and sewage system; changes in the industrial base of the community; health manpower changes; transportation changes which have affected the delivery of health care; and changes in the level of cooperation and coordination of health and allied services.

4. Other Health-Related Community Factors

As was noted earlier in the ACHSSO, the scope and depth of a community study may vary considerably. For the purposes of a study of the health needs and resources of the community (i.e. the focus of the ACHSSO) the emphasis in the following pages will be on the factors identified by a large number of health experts as being of primary importance to the planning and delivery of health care and social services. The most frequently mentioned factors include: population (age structure and sex distribution), household, housing and family characteristics; education; employment; income; ethnic composition and religion.

The most detailed information about these characteristics of a community is gathered by Statistics Canada when the census is taken every ten years (less extensively, every five years). The smallest unit for which information about the factors mentioned is available is the census enumeration area. In rapidly expanding or declining communities, much of the census information may be outdated by the time the information is available from Statistics Canada, or by the time a given community health self-study (or other community study) is undertaken.

Introductory Comments and Sources of Information

F. 2 Miscellaneous Factors

1. Transportation

(a) Road transportation: mobility is affected by the condition of the roads (particularly in the winter).

(b) Air transportation: Location of an airport/strip in or nearly the community is related to health needs. In many communities, air transportation is used for emergency ambulance service.

2. Communications

The JPC should document the presence or absence of the following:

(a) T.V.: availability; quality; number of channels

(b) Radio: number of stations

(c) Newspapers: Which newspapers can be bought in the community, which are published locally; how frequently they are published.

(d) Telephone: number of homes not served by telephone (it is the most convenient method of notifying health professionals of emergency problems). A.G.T. can inform the JPC of the number of dwellings which do not have a telephone.

3. Library

Library services are important for the whole community (particularly for the older and younger age groups).

Analysis and Interpretation

1. Transportation:

Are there specific groups in the community which encounter transportation problems (e.g. the aged)? What is the snow clearance situation in the community? In the past, has this led to problems related to health (eg. getting to the hospital)? Describe the location, uses, and size of the airport? Can it be used at all times? Is there a regular air service to a large urban community? Is the airport used for health emergencies? Does it have this potential?

2. Communication:

What are the shortcomings of the communication systems in the community? Indicate strengths and weaknesses of T.V., radio, telephone, newspapers.

Radio There is a choice of _____ radio stations. The most popular radio station is _______, which broadcasts ___ (hours) and what types of programs.

Newspapers Note which are available in the community and how often they are published, as well as the names of the publisher of the local daily or weekly.

3. Library:

What library facilities/services does the community have?

Local Situation

F. 2 Miscellaneous Factors

1. Transportation:

2. Communications:

Radio:

T.V.:

Newspapers:

Telephone:

3. Library:

Introductory Comments and Sources of Information

F. 2 Miscellaneous Factors (Cont.)

4. Tourism

Tourism is not only of economic and social importance to a community, but it also affects the delivery of health services in the community. This applies especially to tourist and recreational resorts, where the population may swell considerably during the tourist season.

5. Recreation

The availability of recreational services and facilities can be assets to a community and can contribute to its health and quality of life, as well as to its problems. Recreation resources are either public, private, or commercial. Recreational facilities and services often contribute to a reduction in crime and delinquency. Playgrounds tend to contribute toward the development of teamwork and leadership among children.

6 Culture

Cultural facilities are an asset to a community and provide for social activities and outlets.

7. Political Situation

A listing should be made of local politicians presently in office within local, provincial, and federal government. Politicians can often contribute significantly to the promotion of health and health care services, and it will be of value to the JPC to learn from the politicians in the hospital district whether they would be willing to study the health study recommendations put forth by the JPC.

Analysis and Interpretation

4. Tourism:

What is the community's situation with respect to tourism and recreation? (Specify if this situation differs between summer and winter) Are tourism and recreation important factors in the social and economic life of the community? If tourism is a seasonal aspect of community life, what demands does this make on the health and social services of the hospital district? Are the relevant agencies able to provide the services needed?

5. Recreation:

What recreational facilities and opportunities exist in the community? List the facilities and type of use. Also indicate frequency of use (e.g. whether the facilities are used by large numbers or only by a small segment of the population). What probrams are being offered by the community's recreation department.

6. Culture:

What are the cultural facilities and assets of the community? Are they a source of local pride? What programs are being operated by the Department of Recreation, Parks and Wildlife? By the Department of Culture?

7. Political Situation:

Are there any health issues which the politicians have considered important during the past two years? What health programs do the politicans favor? Oppose?

F. 2 Miscellaneous Factors

4. **Tourism:**

5. **Recreation:**

6. **Culture:**

7. **Political Situation:**

Introductory Comments and Sources of Information

F. 2 Miscellaneous Factors (Cont.)

8. Associations

Associations (leagues, clubs, organizations, societies) are an important characteristic of community life in North America. Even the smaller towns in Alberta may have associations exceeding fifty in number.

It is important to list which associations exist in the community. The list should be updated annually. JPC members will likely be able to name many of the associations in the community (if the names are not already available from a community resources directory).

An outline of the organizations in a community could include the following groups: economic, government, planning, housing, education, fraternal, recreation, religious, cultural, welfare, groups for children and youths, health, intergroups relations groups and community organization groups.

Analysis and Interpretation

In the outline, the following information should be listed for each group:

Name
Principal function
Other functions
Whether the organization is open to both males and females, or only one of these
Number of members
  male _____
  female_____
Meeting place and time
Address (if different from the location where the meetings are held)
Age distribution of members
  adults _____
  teen-agers _____
  children _____

Information about membership requisites may be listed, as well as other pertinent information.

F. 2 Miscellaneous Factors

8. Associations:

Introductory Comments and Sources of Information

F. 2 Miscellaneous Factors (Cont.)

9. Public Services Information

(a) Municipal/Civic: Local governments are official bodies providing many of the essential services in the community. It is important that the strengths and weaknesses in the operation of these bodies be examined in health-related areas.

The community's administrator will be able to provide the JPC with an account of the services rendered by the local government. Annual reports and council minutes might be studied as these will reveal which health-related issues and concerns were dealt with and what action was taken.

(b) Provincial and federal government: A community resources directory would reveal the names of government departments and the services provided:

(c) Other providers of public services: Certain essential services may be provided by private companies, (e.g. gas and electricity). It may be useful to document which private companies provide public services, and what plans exist for expansion or reduction of services.

Analysis and Interpretation

F. 2 Miscellaneous Factors

9. Public Services Information:

(a) Municipal/Civic:

(b) Provincial and Federal Government Services:

(c) Private Companies Providing Public Services:

Introductory Comments and Sources of Information

F. 3 Population Characteristics

In Alberta the population increased by 22.2% between 1961 and 1971, reaching a total of 1,627,874. Between 1971-1976, the increase was %.

The number and percentages of the population falling within the various age groupings may be obtained from census data, municipal statistics, and by a population count of the community. The percentages obtained may be plotted as a histogram.

As there is a strong relationship between ill health and age it is very important to have up-to-date information about the age structure of the community. In boomtowns and other rapidly growing communities, it may be advisable to conduct a population census in order to obtain data which reflect more accurately current population characteristics.

When considering the information about family structure, household composition, and population of the community, the JPC should consider whether projected growth of the community is likely to bring about drastic changes in these factors. Whenever possible, growth projection figures should be obtained. (e.g. from the Planning Branch, Department of Municipal Affairs).

Analysis and Interpretation

F.3 Population Characteristics:

What was the percentage increase or decrease of the population between 1961 and 1971, and between 1971 and the present?

What does the shape of the histogram reveal about the age structure of the population? Is it top-heavy (well above provincial average of older people), or is it bottom-heavy (well above provincial average of infants and children? What are its implications in terms of health and services needs?

In many smaller rural communities in Alberta there is a tendency for young people over the age of sixteen to leave the community, often to seek employment or further education elsewhere.

Some rural communities tend to attract retiring farmers. Does this apply to the community? What are its implications in terms of health needs and resources, social and recreational facilities, etc.?

What does the age distribution tell you about the economic burden of the non-productive groups (children below the age of fourteen and over the age of 65.)?

If the community is losing its youth, what are the implications for the community spirit, the labor force, business, recreation, etc.?

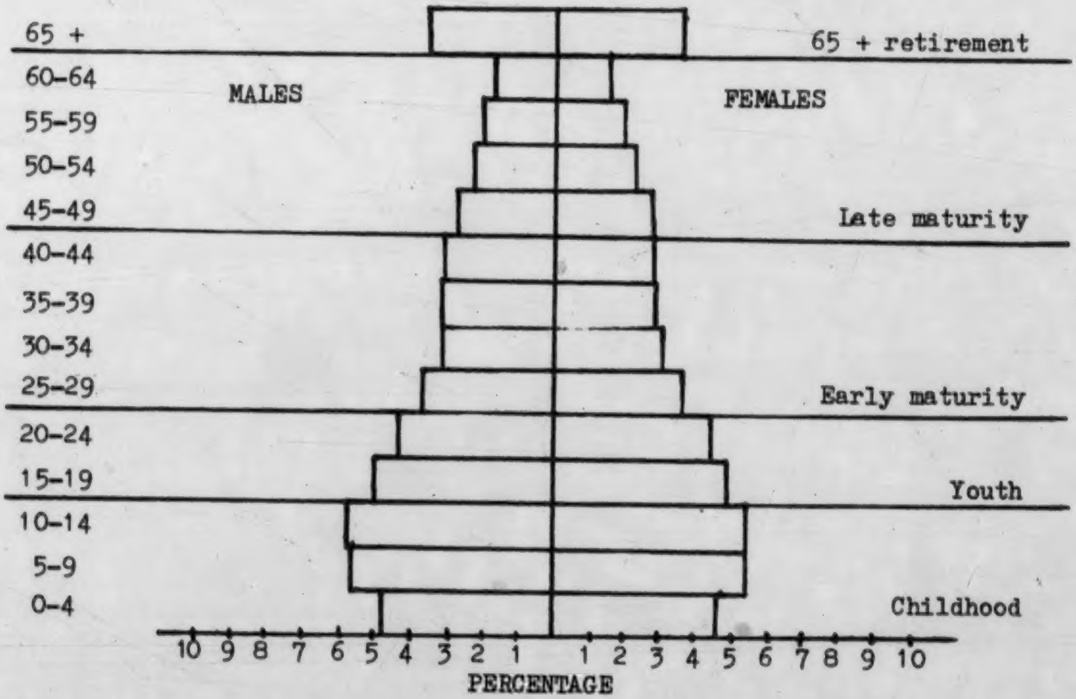
F. 3 Population Characteristics:

(a) The age structure of the community's population in 1971 was: (Repeat for latest year for which data are available, and compare)

Total Population by Age Groups for Males and Females

	Males		Females		Total
	Number	%	Number	%	Number
Under 5 years					
5 to 14 years					
15 to 24 years					
25 to 34 years					
35 to 44 years					
45 to 54 years					
55 to 64 years					
65 years and over					

(b) The histogram below portrays the age and sex distribution for Alberta as a whole in 1971. Superimpose the community's age and sex structure, using the percentages of the above table.



Discuss how age and sex structure of the community differs from that of the Province:

Introductory Comments and Sources of Information

F. 4 Sex Ratio

The sex ratio of a population is the number of males per 100 females.

F. 5 Dependency Ratio

This is the percent of the population in the production category divided by the percent in the non-production category. (It is otherwise defined as the proportion of the total population under 18 years of age and 65 or older)

F. 6 Households:

A household consists of all individuals occupying a given dwelling. It includes all members of the family(ies), lodgers, and their families, employees and their families, and other members of the household.

In 1971 there were 464,943 households in Alberta, which was an increase of 32.9 percent over the 1961 total. The average number of persons per household in the Province was: 3.7 (1961); 3.6 (1966) and 3.4 (1971).

Analysis and Interpretation

F. 6 Households:

Has there been an increase or decrease in the number of persons per household in the community between 1966 and 1971, and between 1971 and the present?

F. 4 The Sex Ratio of the community is ________ (19__)

(The sex ration of a population is the number of males per hundred females)

F. 5 The Dependency Ratio of the community in 19__ was _______.

(The dependency ratio is the percent of population in the production category divided by the percent in the non-production category. It is otherwise defined as the proportion of the total population under 18 years of age and 65 and older)

F. 6 Households:

Using 1971 census data and latest census or other data indicate:
The total number of households in the community in 1971 was _________.
The total number of households in the community in 19__ was _________.
Additional household information according to the following characteristics may be obtained and the findings attached on separate sheets. Indicate which household characteristics have been/will be obtained:

Household heads by sex (   )
Household heads by marital status showing sex (   )
Household by type (   )
Households by number of persons (   )
Households by number of families (   )
Household heads by sex showing age (   )

Introductory Comments and Sources of Information

F. 7 Families

A family consists of a husband and wife (with or without children who have never been married, regardless of age) or a parent with one or more children never married, living in the same dwelling. A family may consist also of a man or woman living with a guardianship child or ward under 21 for whom no pay was received. The "Head of the Family" is the husband in a husband-wife family, or the parent in a one-parent family. Non-family persons include those living alone, or persons not related to each other living in a household.

Family characteristics (such as total number, age and sex of the family head, average number of children per family and the percent of change in these characteristics) are relevant to the health profile of the community. The average number of persons and children per family in the community may be compared with those for the Province, which were; respectively:

1961 -- 3.8 -- 1.8
1966 -- 3.9 -- 1.9
1971 -- 3.8 -- 1.8

Between 1961 and 1971, the total number of families in Alberta increased by 25 percent, from 305,671 to 382,112.

F. 8 Income

Data about family income may be obtained from the census data available on the community. For years other than census years, data about family income must be estimated, as there are few other accurate sources of information about family income.

The regional office of ASS&CH will be able to provide an indication of the level of public assistance within the community.

Analysis and Interpretation

F. 7 Families:

How do the data compare with averages for the Province? What are its implications for the health needs of the families? What are its implications in terms of health manpower and other health resources? What is the percentage of younger and older families in the community? Are there many large families? Are there many families without infants and school attending children?

What was the increase in total number of families in the community between 1961 and 1971, and between 1971 and the present?

F. 7 Family Characteristics:

Using 1971 census data and latest census or other data indicate:
The count of total families in the community in 19__ was ________.
The count of total families in the community in 19__ was ________.
This represents an increase of ______%
Additional information about family characteristics may be obtained, and the findings attached on separate sheets. Indicate which family characteristics have been/will be obtained:

Families by age of head ( )
Families by number of persons ( )
Families by number of unmarried children (aged 0-24) ( )
Families by marital status and sex of head ( )
Families by schooling level ( )
Family heads by occupation ( )
Total non-family persons by household status and sex ( )

Comments about families and their characteristics:

F. 8 Family Income:

What was/is the average family income for the community's population during the years:

Community		Alberta	
1961	________	1961	________
1966	________	1966	________
1971	________	1971	________
1976	________	1976	________
19__	________	19__	________

The average family income of the community compared to the Province suggests:

Introductory Comments and Sources of Information

F. 9 Education

Information about enrolments in the local public school system may be obtained from the annual reports of the superintendent of schools. Data from annual reports will allow identification of school enrolments over the years (e.g., reflect the effects of the postwar "baby boom"). It is important to note the location of schools within the community, what type they are, what the teacher-pupil ratio is for each school, whether there is a school counsellor at the school, and what health-related educational courses are offered. Similar information should be obtained for separate schools, or special schools in the community. Educational levels are related to health concerns and to utilization of health services. It is therefore considered wise to gear the health education activities to the educational level of the recipient.

Individuals with four years or less of formal schooling are usually designated as technically or "functionally illiterate" since they generally have difficulty in reading and understanding many forms of communication.

Analysis and Interpretation

The following are some questions which may be asked about the educational level of the population of the community:

1. Are there many people in the community who are "functionally illiterate"?
2. Has it been possible to estimate the number of children and adults who are mentally retarded/handicapped? What percentage of them attends school?
3. What is the number of schools in the community?
   Separate schools ________
   Public schools ________
4. What is the number of high school graduates per year?
5. Are there future school construction plans?

F. 9 Education:

(a) Obtain the following census data on educational level for the community for 1971 and latest year possible

Population Aged 15 and over by Level of Schooling for Males and Females	1971	19__
Males: Less than Grade 5		
Grades 5 - 8		
Grades 9 - 10		
Grades 11 - 13		
With Other Post Secondary		
Without Other Post Secondary		
Some University		
University Degree		
Females: Less than Grade 5		
Grades 5 - 8		
Grades 9 - 10		
Grades 11 - 13		
With Other Post Secondary		
Without Other Post Secondary		
Some University		
University Degree		

(b) Persons aged 5 and over attending school full time by Schooling Level for Males and Females: (as per 1971 and latest census data)

	Females	Males	Total
Kindergarten			
Grade 1			
Grade 2			
Grade 3			
Grade 4			
Grade 5			
Grade 6			
Grade 7			
Grade 8			
Grade 9			
Grade 10			
Grade 11			
Grade 12			
Grade 13			
University 1-2 Years - No Degree			
University 3 Years - No Degree			
University with Degree			

Introductory Comments and Sources of Information

F. 10 Ethnic Background

The JPC can readily find 1971 census information about the ethnic composition of the census district in which the hospital district is located from Statistics Canada. The Statistics Canada catalogue will tell the JPC whether this information is available about the particular community of interest. Should the JPC be of the opinion that it is important to know the ethnic composition figures about the community, these may be obtained from the enumeration area figures (at a cost) via the Information Service of the Alberta Bureau of Statistics. Ethnic background provides important health-related information as many older immigrants in Alberta have only learned marginal English. This may pose problems in terms of following medical orders, and self-dentification of symptoms.

Analysis and Interpretation

If there are ethnic or racial minority groups in the community, do they have any special health problems? If so, what is the nature of these problems? (The term health problems is here used in a very broad sense, and factors such as difficulty or inability to understand instructions for taking medications or conducting self-examinations is meant to be included). Are these problems age-related? Are they chiefly those of physical health? Hygiene? Mental Health? Alcohol-related? etc.

F. 10 Ethnic Background:

Ethnic Groups for Males and Females:

Ethnic Group	Males	Females
British Isles		
French		
Asiatic		
Austrian		
German		
Hungarian		
Italian		
Jewish		
Native Indian and Eskimo		
Netherlands		
Polish		
Russian		
Scandinavian		
Ukrainian		
Other and Unknown		

Introductory Comments and Sources of Information

F. 11 Working Population and Employment Data

The number of people in the work force, the employment rate of these individuals, and the distribution of the working population by industry and occupation are economic factors which have important implications for many areas of health and medical care.

Businesses are of many types, and may be classified into major industrial categories as defined by the Census of Canada. Compiling an inventory of the businesses located within the community is one means of gathering information about the industrial base of the community. If such a task is undertaken, it might also be useful to indicate the number of workers employed in each industrial category.

The customers of a community's businesses and industry are drawn not only from within the community's boundaries, but often also from beyond. The area from which customers are drawn is known as its Trading Area.

If the JPC wants to study more intensively the industrial aspects of the community, it might asecertain if the Research Planning Section and the Provincial Planning Branch of the Department of Municipal Affairs has in recent years completed a regional study report.

Analysis and Interpretation

F. 11 Working Population and Employment Data:

1. Has there been a substantial shift in the community's economy in recent years? (for example, from a heavy reliance on farming to an increasing dependence on manufacturing and commerce) How is this shift reflected in the work force?

2. What are the major employment, industrial, and occupational aspects of the community and what health problems does this economic situation pose?

3. The percentage or number of unemployed may be examined. Is unemployment high compared with other communities in the county? Compared with the Province? What are the main causes of either temporary and/or permanent unemployment?

4. Is anything being done to attract industry to the community? If "yes", elaborate.

Local Situation

F. 11 Working Population and Employment Data:

Non-Manufacturing Employment:

Name of Company	No. of Employees	Type of Business

Manufacturing Employment:

Name of Company	No. of Employees	Type of Business

SECTION F: Studying the Communities in the Hospital District

Local Situation

(a) Distribution of Community Labour Force by Occupation:

Using 1971 Census data, obtain the following employment data and repeat for latest year possible:

Population Aged 15 by Labour Activity; Experience for Males and Females:	
Males: In Labour Force	
- Employed	
- Unemployed	
In Experienced Labour Force	
- Worked in 1970	
- 40 to 52 weeks	
- Mainly Full Time	
Not in Labour Force	
- Worked Since January 1, 1970	
- Worked in 1970	
- Did not work since January 1, 1970	
- Worked prior to January 1, 1970	
Females: In Labour Force	
- Employed	
- Unemployed	
In Experienced Labour Force	
- Worked in 1970	
- 40 to 52 weeks	
- Mainly Full Time	
Not in Labour Force	
- Worked Since January 1, 1970	
- Worked in 1970	
- Did Not Work Since January 1, 1970	
- Worked Prior to January 1, 1970	

Using 1971 census data, obtain the following employment data and repeat for lates year possible:

Experienced Labour Force by Class of Worker for Males and Females:		
- Males: Wage Earners (incl. self-empl. in corporations)		
- Worked 40 - 52 weeks in 1970		
- Mainly Full Time		
Self Employed (unincorporated)		
Unpaid Family Workers		
-Females: Wage Earners (incl. self-empl. in corporations)		
- Worked 40 - 52 weeks in 1970		
- Mainly Full Time		
Self Employed (unincorporated)		
Unpaid Family Workers		

Local Situation

F. 11 From the latest census data available, determine the following: (indicate year of census data used)

Experienced Labour Force by Occupation for:	Males	Females
Managerial, Administrative, and Related Occup.		
Teaching and Related Occup.		
Occupations in Medicine and Health		
Technological, Social, Religious, Artistic and Related Occup.		
Clerical and Related Occup.		
Sales Occupations		
Service Occupations		
Farming, Horticulture, and Animal Husbandry		
Other Primary Occupations		
Processing Occupations		
Machining, Product Fabricating, Assembly and Repair		
Construction Trades Occupations		
Transport Equipment Operating Occup.		
Materials Handling, Other Crafts, and Occupations Not elsewhere Classified		
Occupation Not Stated		

From the latest census data available, determine the following: (indicate year of census data used)

Experienced Labour Force by Industry for:	Males	Females
Agriculture		
Forestry		
Fishing and Trapping		
Mines (incl. milling), Quarries and Oil Wells		
Manufacturing		
Construction		
Transportation, Communication and Other Utilities		
Trade		
Finance, Insurance, and Real Estate		
Community, Business, and Personal Service Industries		
Public Administration and Defense		
Industry Unspecified or Undefined		

Introductory Comments and Sources of Information

E. 12 Housing

Census information about the total number of dwellings and of dwellings by the types listed across page is available for each enumeration area. Consult the census catalogue to see if the data is available in one of the census bulletins listed in the catalogue. If the data are not available, they can be obtained at cost via the Alberta Bureau of Statistics. If the JPC intends to do a house to house survey in the community, questions used in the census could be asked.

Good housing and residential areas are some of the most important assets of the community. The home is the one place where the community member is likely to spend most of his/her leisure time. The home and residential area form the place where most of the non-working and non-schooltime hours are spent. The number of rooms and size of the family are health-related factors. All individuals have some need for privacy and personal space. The style of family living is inevitably affected by the physical layout and the space available in the house, and that of a garden during the summer.

Analysis and Interpretation

E. 12 Housing:

Is there a shortage of homes in the community? Which type—owned or rented or both? Has this been a long-time or a recent phenomenon? Is there an excess of housing available? Of old ones, or new ones?

Are people who wish to own or rent a home able to do so (in terms of availability, apart from other reasons, such as cost)? If the housing is available, does cost prohibit ready occupation in both categories? What are the implications of the answers to these questions in terms of health and community well-being?

How many, or what percentage, of the homes have been recently constructed and how many were constructed before 1946? Older homes may still be very solid and a strength to the community, or they may be a weakness. Are there many old homes which lack toilet, bath and other facilities? Is it the older people who live in these homes? If so, what are the implications for such services as home care, or meals on wheels?

What is the age mix in neighbourhoods? Are there wealthy areas in the community, poor areas, new housing developments? Do houses all look the same in the same area? Do gardens look attractive, and are trees planted along the streets?

Local Situation

F. 12 Housing:

The count of total dwellings in the community in 19__ was _________.

Additional information which might be obtained about the housing of the community includes the following:

Dwellings by Tenure
Dwellings by Type
Dwellings by Number of Rooms
Number and Percent of Dwellings by:
method of sewage disposal
by period of construction
by number of bedrooms
by source of water supply

Comments on the community's housing situation:

PART II: HEALTH AND HEALTH SERVICES PROBLEM IDENTIFICATION

Introduction

Sections A, B, C, D, E and F of Part I were concerned with the study of the background factors of a hospital district and its communities, and with the organization for conducting a health self-study. In Part II, the focus will be on the status of health, the organization of health care delivery, and the strengths and weaknesses therein. Part II consists of three main areas of enquiry: (1) the organization of health care services; (2) personal community health and related services; (3) environmental health and related services.

The format of Part II resembles that of the sections of Part I. For example, again, under "Introductory Comments and Sources of Information" relevant background information is provided, the main points of interest or the major concerns are highlighted, and sources of information are identified. Under "Analysis and Interpretation" questions are asked, or suggestions are made, which professionals specializing in the particular subject area feel are relevant to community health study. References are also listed under this heading. The tables and questions on the right hand pages (these pages always contain the heading "Local Situation") provide guidelines for systematically enquiring into the health status and problems of the community. The right hand pages also aim to serve as a format for recording the findings obtained. Most of the tables have been borrowed in whole, or in part, from the document: "A Self-Study Guide for Community Health Action Planning", published by the American Public Health Association (1967). Where necessary, adaptations have been made to take into account the health and health care conditions and terminology which are specific to Alberta.

The questions asked in Part II aim to provide checkpoints to determine whether in a particular health sub-area (e.g., chronic diseases, occupational health) there are specific problems of some magnitude, and whether the health services directed toward the solution of the particular health problems are adequate, limited, or not provided at all.

It should be noted that the questions asked in Part II are by no means all-encompassing; rather, they provide a frame of reference for enquiry into health problems and the amounts and kinds of health services that citizens might justifiably expect from their community.

Each community is unique and has its own personality. This also applies to a hospital district since each district varies in terms of health conditions, needs, and services. Because of this, and because health needs of a community may change rapidly, it is advisable that the JPC members and others involved in a community health self-study, should avoid establishing rigid standards for making judgments about health services. It is wiser to keep standards flexible, so that a community (or a hospital district) can strive toward the achievement of practicable goals, rather than fail to satisfy impracticable standards.

Sections B and C of Part II cover most health sub-areas. When confronted with these sections, the initial reaction of the JPCs may be that it would be too great a task to examine all of these subject areas. The JPC may well decide, as have some other health study groups, that it should initially concentrate on only certain health sub-areas, especially those areas about which there is already some consensus among the JPC members that they present the more prominent health problems of the community.

A decision to study only some of the health sub-areas listed in the ACHSSO, or a decision to study all, or most of, these areas, will have some influence on the organization of the study. In community health studies carried out in the United States, some study groups established a committee for each health sub-area, (or for a cluster of health sub-areas) which presented problems which the group hoped to study and resolve. The following is a list of some approaches which were used:

1. to study only special health areas presenting critical problems (within a given year).
2. to study concurrently the entire field of health services on a systematic basis.
3. to study the entire field of health services sequentially over a number of years -- such as, environmental health one year, mental health another, hospital facilities yet another, until all community health services have been surveyed.

In the identification of, and in the process of seeking solutions to, a specific health problem, it is desirable to obtain the advice of health professionals having a special interest and competency in the particular health area. Such resources may reside within the hospital district, or within surrounding hospital districts. If not, it may be beneficial to obtain the advice of special consultants who are experts in the specific subject area, enjoy a reputation for sound judgment, and who are familiar with guidelines, current accepted practices and goals. The AHSC, A.S.S. & C.H., and universities all have resources which the JPC might call upon to assist with the community health self-study.

As was noted, the questions asked in Part II are not all-encompassing. They are meant to assist the JPC in examining the health and health care delivery of the hospital district. The questions aim to help the JPC to delineate areas in which further study is needed, and to assist in making recommendations for health action planning.

Since there is no such thing as an "average community" and since the questions of the ACHSSO are based on frequent problems encountered, it is likely that every JPC will find, for some of the health sub-areas covered, that there are not enough questions, too many questions, none at all, or perhaps some questions which are not relevant or in need of reframing. Each JPC should thus use the questions as a basic pattern of enquiry which, like all patterns, must be tailored to meet the specific dimensions of the hospital district under study.

In many respects, the material contained in the three Sections of Part II represents checklists of program activities, the absence or duplication of which may indicate problems or needs in health services. The narrative explanations of elements of typical program components, objectives, guidelines, and other comments listed under "Introductory Comments and Sources of Information" aim to assist the JPC in identifying the presence or absence of acute or chronic health problems, the deficiencies in health services delivery organization, cooperation, integration, coordination, etc.

It should be stressed that answering the questions of Part II does not provide a definitive analysis of programs or problem areas. Rather, it serves to provide a starting point from which the JPC can identify probable health-service problems which are of sufficient community concern to warrant either immediate action, or further organization, study, and action to resolve them. To reach this starting point, several steps are suggested:

1. Identify program areas, their problems, and needs by answering the questions of Part II.
2. Evaluate program activities as to their effectiveness or efficiency through discussion -- often this must be by "educated guess" or by the informed opinion of experts at this point because objective data are often not available. For each of the health sub-areas, spaces are provided for checking "A" (adequate), "L" (limited) or "I" (inadequate). This preliminary evaluation is not aimed at specific agencies but at program components and their adequacy in meeting health needs. For example, one agency may be doing an excellent job in providing a service, yet services for the entire community may be lacking, giving cause for further study. Specific examples of weaknesses identified should be enumerated for further attention as appropriate.
3. Next, assess each subject area and make a rough determination of priority in terms of:
   a. Adequacy--The adequacy or inadequacy of presently operating programs to meet the present need and the anticipated need for the next few years.
   b. Coordination--The extent to which the programs of the different public and voluntary agencies and private practitioners in the community which serve in this subject area are coordinated or uncoordinated. Instances of gaps, overlapping, or inefficient duplication should be footnoted.
   c. Further study--The judgment of the JPC (or the particular study committee) as to whether the priority for further study is high or low. If the priority is high, consideration should be given to assigning this subject area to a committee for further study. (Schedules to facilitate such further study will be found in Volume Two, Part C of the American Public Health Association's publication "A Self-Study Guide for Community Health Action-Planning", 1967).

A Procedural Note for Completing the Questions of Part II

Whenever names of agencies or separate localities are to be listed, it is recommended that a code be developed for the entire list of agencies and that the code letters be inserted in the table. This will save time, effort and space. It is advisable to establish a standard code prior to undertaking the health self-study and to use the same code throughout the study. One method by which this can be done is to construct a simple table in which localities (such as towns, villages, counties or districts) are entered on one axis and agencies are designated on the other axis. (See following table).

Such a table (master code) serves an additional purpose. It provides a quick visual picture of the number and scope of health agencies within the hospital district and provides an indication of the duplication or gaps in health services organization.

If sufficient space for recording answers or explanations is not provided on the right hand pages for each of the health sub-areas, supplementary sheets should be used.

Closing Comments

Since the hospital district consists of different political-geographic units, the JPC members may question the applicability of some of their findings to the entire hospital district. For example, a certain health problem in one locale may not be evident in another locale within the hospital district. It is important, however, to identify which community has what problem, and of what magnitude, so that planning to resolve particular problems may be based on a firmer foundation.

It is possible that the self-study process will be started in one community and will have progressed considerably before the same process is started in another community. It may be fruitful for the JPC to begin the health study by focusing on the largest community in the hospital district (often the county seat) since there are likely to be more resource people there than in the smaller communities. When the largest community is a city, and the task of doing a comprehensive community health self-study is felt to be too great, it may be advisable to begin the health study by focusing on one of the smaller communities in the hospital district. Lastly, the JPC might anticipate that the progress of the health study will proceed at different rates in the various communities.

Locality or Jurisdiction (County; I.D.; S.A.; Town; Village, etc.)	Agency (Names and code numbers 1-X)													
	1 Health Unit	2 Auxil. Hosp. & Nursing Dist.	3 Region of the A.S.S. & C.H.	4 Hospital District	5 Services for the Handicapped Region	6 Alta. Mental Health Services Region	7	8	9	10	11	12	13	X
A County ___________														
B County ___________														
C														
D														
E Town of _________														
F														
G														
H														
I														
J														
K														

Code: If an agency provides (a)service(s) in the locality/jurisdiction listed under A - K, record same by filling in an X in the box crossed by the agency axis and the locality axis.

Enter Names of other Agencies providing services within the hospitl district.

SECTION A

QUESTIONS ABOUT:

ADMINISTRATION OF HEALTH CARE SERVICES

A. 1 Community Planning and Coordination of Health Services

Introductory Comments and Sources of Information

Planning for the health care of a community is often limited because it fails to coordinate the various aspects of the health care delivery system. Health problems may also be created due to planning and action in non-health fields. For example, in the process of erecting a day care center in an Alberta community, it was realized that its site (an abandoned garbage dump) was dangerous since noxious gases were still being emitted.

Coordination is needed between the various areas of the health system, and between the health field and other fields related to health. Coordination, which can be voluntary or coerced, can occur on different levels. For example, those planning sewage systems and garbage disposal sites are required by law to work in conjunction with the public health inspector. On the other hand, planners in other areas (such as transportation) are not required to consult with health professionals, a situation which may be detrimental to the interests of the community.

In an attempt to promote coordinated planning among health professionals and agencies, the A.H.S.C. has encouraged hospital boards throughout Alberta to establish Joint Planning Committees (JPCs) which would be representative of the community. The objectives of these committes, according to the A.H.S.C., are the following: "to evaluate the effectiveness of existing programs in relation to the entire spectrum of the health care delivery system and to promote the development of the cooperation and coordination necessary to bring about high quality of care and optimum efficiency and economy in the use of community and district resources." (A.H.S.C. Annual Report, 1972: 9)

Analysis and Interpretation

1) Who is planning? Identify planning groups--both health and non-health--which are operative in the hospital district.

2) What mechanisms exist to coordinate planning efforts of various agencies and groups and their programs?

3) Does a representative inter-agency (community) planning group exist?

4) Have there been periodic planning meetings between say, the Hospital Board, the Recreation Board(s), the P.S.S. Board(s), the School Board(s), etc., to discuss coordination and other mutual concerns directly or indirectly related to health?

5) Communities may have several planning groups in health, such as hospital boards, mental health advisory committees, P.S.S. Boards, local boards of health. How are the plans and findings of the various health planners coordinated in regard to (a) planning; (b) implementation, and (c) evaluation?

6) What are the present barriers to the achievement of coordination among health and social service agencies and professionals? Are they chiefly attitudinal?

A. 1 Community Planning and Coordination of Health Services

Local Situation

(a) Identify the groups in which community planning regarding health is a primary activity.

Area of Concern	Agency or Planning Group	Evaluation		
		A	L	I
1. Health-related planning:				
Community Health				
Hospitals & Facilities				
Medical Care				
Mental Health				
Social Services				
Home Care				
Dental Care				
Other (specify)				
2. Non-Health Planning:				
Economic Development				
Adult Education				
Land Use				
Agriculture				
Transportation				
Town Planning				
Schools				
Day Care				
Recreation				
Early Childhood Services				
Other (specify)				

(A = Adequate L = Limited I = Inadequate)

Coordination - What is being done to coordinate the various planning efforts? (Specify)

Based on the JPC's evaluation of this Section ( ), overall community planning efforts appear to be:

a. Adequate ______ c. Inadequate ______

b. Coordinated ______ d. Uncoordinated ______

and priority for further study and action is:

a. High ______ b. Low ______

A. 2 Organization for Health Srrvices

Introductory Comments and Sources of Information

Community health services are the sum of the organized efforts of a number of organizations, both governmental and non-governmental (voluntary and private). In Alberta, the majority of community health services are provided by personnel employed directly or indirectly by the provincial government. Most of the health services in Alberta are funded by the provincial government, which, in turn, receives cost sharing from the federal government.

The Department of Social Services and Community Health of the Province of Alberta (A.S.S. & C.H.), through its various divisions and branches, provides health services in a number of health areas. As of January 1976, there were 129 general hospitals in the Province (located in 104 hospital districts). The federal government operates eight hospitals and nursing stations in Alberta. One federal hospital is located in Calgary (the Colonel Belcher Hospital) and another in Edmonton (the Charles Camsell Hospital).

The Alberta Alcoholism and Drug Abuse Commission (A.A.D.A.C.) has primary responsibility for the treatment and prevention of drug abuse and alcoholism.

The government's RITE telephone directory is a useful source for ascertaining which department, branch or division of the Government of Alberta has responsibility for a particular health area. In addition, the AID service of Edmonton publishes the "AID Directory of Community Services" for Edmonton and District. This directory is an excellent source of information about the agencies and organizations providing particular health and social services. Many of the organizations listed provide services and resource materials to other parts of the Province. The AID Directory may be obtained (for a fee) from: AID Service of Edmonton, #203, 10711 - 107 Avenue, Edmonton.

Recommendations regarding the organization of health services in Canada have been made in a number of reports on health care. This literature may be borrowed from the library of A.S.S. & C.H. located in the Administration Building, Government of Alberta.

Further, a listing of the Department's various divisions and branches may be obtained from the Department's head office in Edmonton (Administration Building).

Analysis and Interpretation

A. 2 Organization for Health Services

Local Situation

(a) Identify major health organizations/agencies providing services in the hospital district:

Organization	Jurisdiction Code(s)*		
Governmental - Federal Dept. of National Health and Welfare (specify branch)			
Governmental - Provincial A.S.S. & C.H. (specify branch/ division)			
Non-Governmental Agencies (specify)			
Nursing Homes (specify)			
Hospitals (specify)			

Coordinating Mechanisms - What mechanisms exist to foster and facilitate cooperative, coordinated program activities between and among these agencies and organizations? (specify)

A. 3 Community Health Services

Introductory Comments and Sources of Information

In Alberta, the organizational and administrative pattern of health services is reasonably well-defined. The items listed as index questions (opposite page) identify areas in which local health agencies have recognized community responsibilities.

The public health responsibiliites for every community in the Province are within the jurisdiction of either a health unit or a city health department. The local health units should be adequately financed and staffed with full-time, trained personnel. The personnel should be expected to assume leadership in planning comprehensive health programs and organizational services.

Most voluntary health agencies limit their services to particular disease groups (such as heart disease, tuberculosis, cancer, diabetes). They provide public education programs; support research; and assist in professional training. Some provide direct service to patients.

In some instances, more than one agency provides services in one disease area. For example, mental health services may be provided by both a health unit and Alberta Mental Health Services. Such duplication can be beneficial if there is coordination and if each service complements the other. However, duplication can also be inefficient and uneconomical.

Voluntary and governmental health agencies sometimes have inadequate staff in terms of numbers and professional training. This may limit effectiveness and efficiency.

Physical facilities also have significant influences on the ability of agencies to perform health services functions effectively and efficiently. These facilities should be evaluated for adequacy (e.g. space, location, accessibility, modern equipment), and for other factors, such as personnel. financing, and the protection of anonymity.

Analysis and Interpretation

1) Does the local board of health feel that the health unit receives adequate funds from the provincial government in order to provide needed services? Is the health unit considered to be well-staffed? If not, where are the gaps?

2) What are the training/qualification requirements for the health unit staff?

3) In what areas has the health unit demonstrated leadership in planning?

4) Which voluntary health agencies are active in the hospital district? Evaluate their efforts. Are these agencies adequately staffed? Are their staff adequately trained?

5) Assess the situation with respect to the duplication of services.

A. 3 Community Health Services

Local Situation

(a) Program Areas - Identify health programs by governmental and other agencies operating in the hospital district

Program Activities	Providing Agencies* and Jurisdiction Code(s) area not covered	Evaluation		
		A	L	I
Accident Prevention				
Audiology Clinics				
Alcoholism and Drug Abuse prevention/rehabilitation				
Chronic Disease Control				
Communicable Disease Control				
Tuberculosis				
Venereal Disease				
Epidemiology				
Dental Health				
Emergency Health Services				
Family Counselling				
Family Life Education				
Family Planning				
Food Sanitation				
General Sanitation and Waste Disposal				
Home Care Program				
Homemaker/Home Help				
Laboratory Services				
Maternal, Child Health				
Meals on Wheels				
Medical Social Services				
Mental Health				
Mental Retardation				
Nutrition Consultation				
Occupational Health				
Oral Fluoride Program				
Parent/Child Development				
Rehabilitation				
Services for the physically handicapped (crippled children, other (specify)				
Speech Clinics				
Other (specify)				

(A = Adequate L = Limited I = Inadequate)

*The providing agency may be a local, regional, federal or provincial agency, or a professional in private practice, and should be indicated.

A. 3 Community Health Services

Local Situation

(b) Administrative and Support Activities - Identify administrative and support activities of health programs by governmental and non-governmental agencies in the hospital district:

Program Activities	Providing Agencies	Jurisdiction Code(s) (Area not covered)	Evaluation		
			A	L	I
Ambulance Services* Air					
Road					
Coordination of Agency Programs					
Equipment Loan					
Health Education and Promotion					
Professional Development (Continuing Education)					
Public Information					
Planning & Evaluation					
Transportation					
Other (Specify)					

(A = Adequate L = Limited I = Inadequate)

*Identify which firms provide ambulance services in the hospital district.

Comments:

Local Situation

(c) Physical Facilities - Determine the adequacy of physical facilities in which health agencies are housed (except for hospitals and related facilities, e.g., auxiliary hospital, sanatorium.)

Agency	Jurisidction Code(s)	Evaluation		
		A	L	I
Governmental (Specify)				
Non-Governmental (Specify)				
Other (Specify)				

(A = Adequate L = Limited I = Inadequate)

Based on the JPC's evaluation of this Section ( ), Community health service programs appear to be:

a. Adequate ______ c. Inadequate ______

b. Coordinated ______ d. Uncoordinated ______

and priority for further study and action is:

a. High ______ b. Low ______

A. 4 Personnel Providing Health Services

Introductory Comments and Sources of Information

In Canada, and elsewhere, two of the major problems in health services delivery are the shortage of health manpower, and the relatively disproportionate distribution of available health professionals. These problems have been aggravated by the continuing trend toward specialization among physicians and other health and allied professionals and by the shift of the population from rural to urban areas.

Uneven distribution of available health professionals is particularly in evidence in Alberta's rural areas, where few communities or hospitals are of sufficient size to warrant and/or attract specialist physicians. Many of the smaller hospitals have difficulty in maintaining 24 hour physician coverage. This problem, and a shortage of nurses, contribute to the fact that the occupancy rates of smaller hospitals are often below full capacity.

There are no easy solutions to these problems, and it appears unlikely that professional training programs (unless major innovations occur within them) will be able to adequately meet all the needs for health personnel in the immediate future. The challenge ahead will be to find ways of utilizing new types of personnel (especially at the sub-professional levels) more efficiently and effectively.

The A.H.S.C. can furnish the JPC with reasonably accurate and up-to-date information regarding the staffing of various hospital departments in the general hospitals within the hospital district.

Analysis and Interpretation

1) Are there significant shortages of physicians or other health personnel? If so, are there any organized plans to attack these shortages?

2) Are there any non-scientific health practitioners operating in the hospital district (e.g., dispensers of folk medicine)?

A. 4 Personnel Providing Health Services

Local Situation

(a) Health Manpower Resources - Identify the number of personnel providing health services in the hospital district, and the number of non-practicing manpower resources

Category	Estimate Equivalent full time*					
	Total		Private Practice	Volunt. Agency	Govt. Agency	Other (Specify)
	Active	Inactive				
Physicians-generalist						
Physician-specialists (List specialty if appropriate)						
Dentists						
Dental Hygienists						
Veterinarian						
Nurses						
BscN						
RN						
Nursing Asst. (CNAs/ Orderlies						
Dietitians						
Heath Educators in:						
Health Unit(s)						
School						
Hospital						
Homemakers						
Hosp. Administrators						
Lab. Technicians						
X-Ray Technicians						
Nutritionists						
Speech Therapists						
Clinical Psychologists						
Medical Social Workers						
Occup. Therapists						
Physiotherapists						
Audiologists						
Optometrists						
Pharmacists						
Chiropractors						
Public Health Inspectors						
Others (Specify)						

*Estimate based on amount of time spent in each category if part-time.

A. 4 Personnel Providing Health Services

Local Situation

Based on the JPC's evaluation of this Section (   ), numbers and skills of available practitioners appear to be:

a. Adequate ______

b. Inadequate ______* (Detail where the shortcomings exist.)

and priority for further study and action is:

a. High ______ Low ______

A. 5 Information Resources for Health Care Referral

Introductory Comments and Sources of Information

"Where and how can I get care when I am sick?" This question expresses one of the chief concerns people have about their health. For those who have been residents in Alberta for some time, and particularly residents in cities and metropolitan areas, the problem of finding out where to obtain care when sick is not one of great concern. For persons having telephones and directories there is little problem in learning the location of medical clinics.

A more critical problem is that some people, especially new residents and transients, do not know where, and how, to obtain medical care in an emergency. This is particularly applicable to the remote areas where there is no local hospital. In such areas, the nearest R.C.M.P. detachment is an excellent source of information. The health unit is another source. All general hospitals in Alberta provide round the clock emergency services. Arrangements regarding routine care and emergency services vary from locality to locality. Some communities which do not have a general hospital might have an ambulance service.

Often, there is no listed telephone number for health emergencies in small communities. There are few "health resources referral centers (or clearing houses)" in Alberta, though they have proved to be of considerable value elsewhere. In Alberta, client referrals among agencies and physicians are generally informal. It may be desirable for the JPC to investigate the feasibility of the establishment of a health resources information center or service in their hospital district. Further, it may be useful to maintain a register of those persons in the hospital district holding a valid first aid certificate and of registered nurses who are not presently practicing nursing.

Analysis and Interpretation

1) Does the hospital district have a health information and referral center?

2) Is there an up-to-date directory of community health agencies and services?

A. 5 Information Resources for Health Care Referral

Local Situation

(a) List sources of information about health and medical services available to people in the community.

Information Source	Providing Agency or Jurisdiction Code(s)	Evaluation		
		A	L	I
Directory of Health & Social Services				
Community Health Referral System				
Physician Emergency Call Service				
Special Information Centers*				
Preventive Social Services				
Other				

(A = Adequate L = Limited I = Inadequate)

*E.g., poison control, alcoholism information, family counselling, etc.

Based on the JPC's evaluation of this Section ( ), information and referral services appear to be:

a. Adequate ______ c. Inadequate ______

b. Coordinated ______ d. Uncoordinated ______

and priority for further study and action is:

a. High ______ b. Low ______

A. 6 General Hospital Facilities and Services

Introductory Comments and Sources of Information

General hospitals are hospitals providing diagnostic services and facilities for medical and surgical treatments in the acute phase for adults and children, and obstetrical care, or any of them (definition of the Alberta Hospitals Act).

Not all hospitals can provide all services. In fact, it would be impossible for each local community to have within its immediate boundaries a full range of medical specialists and specialized hospital care and treatment facilities. It is, nonetheless, important that each community should have reasonably equitable access to the full range of medical services and facilities. If the full range of services and facilities is not available within a community, its members should be able to have access to them without an unduly great time lag. Transportation is therefore an important variable.

A broad spectrum of diagnostic and treatment services should be available within the hospital district. Adequate in-patient and out-patient services are essential. This is in keeping with the accepted principle that acute hospital care is a public "right", and not just a privilege.

The number of hospital beds per thousand population in Alberta is high compared with the other Provinces. But this factor alone does not ensure high quality of care and equity of access. It is the hospitals' responsibility to give high priority to cooperative arrangements with other health agencies and professionals, and to explore the feasibility of using alternate forms of care (i.e. auxiliary hospitals, nursing homes, home care, meals on wheels programs, day hospital and out-patient facilities). By actively participating in such endeavors, the hospital contributes to the provision of complementary and alternative services.

In addition to the AHSC's monitoring functions regarding the provision of hospital services in Alberta, it provides consultative services to all hospitals, their boards and joint planning committees, regarding all aspects of hospital services and facilities.

Analysis and Interpretation

1) Are all the general hospitals within the hospital district accredited by the Canadian Council on Hospital Accreditation? If not, in what respects does the hospital fail to meet accreditation standards? Is it due to the hospital's obsolescence? Is the hospital inadequately equipped?

2) Is a physician available 24 hours per day for emergency service?

3) When considering all hospital facilities and services in the hospital district (as opposed to taking each facility separately), are there any shortages of facilities when considering: (a) beds available; (b) support services (e.g. laboratory); (c) personnel?

4) How are the hospital's out-patient services provided? By means of informal clinics? As part of the hospital's emergency service? Is this knowledge widespread in the community?

5) Are a significant number of patients being cared for in acute, general hospitals who might more appropriately be cared for by other arrangements (such as extended care facilities or home care programs)?

Analysis and Interpretation (Cont.)

6) Are there significant shortages of physicians or other health personnel, and, if so, what is being done, or might be done, about this situation?

A. 6 General Hospital Facilities and Services

Local Situation

(a) Rated bed capacity by type of nursing units as per December 31, 1975:

Name of Hospital	Number of Beds								Accredited by The CCHA			Location
	Medic.& Surgi-cal	Intens. Care	Obst-etric	Pedia-tric	Psych-iatric	Other Short Term	Long Ter m Care	Total Beds	Yes	No	Unk.	

(b) For each of the hospitals identified above, indicate for the last two years:

1) % rated occupancy and 2) Total patient days of care during:

% Occupancy	19__	19__	Total patient days of care during:		
				19__	19__
Med. & Surg. Unit					
Intens. Care Unit					
Obstetric Unit					
Pediatric Unit					
Psychiatric Unit					
Other Short Term					
Long Term Care					
Average % rated occupancy					

A. 6 General Hospital Facilities and Services

Local Situation

(c) For each of the hospitals identified, indicate the availability of the laboratory services described below:

	Available		Number of procedures performed		
Services	Yes	No	19__	19__	19__
Services	Thru Hosp.	Thru outside lab.			
Haematology					
Urinalysis (routine qualitative)					
Biochemistry					
Bacteriology, Microbiology, Virology					
Histo-pathology & Cytopathology					
Blood Bank					
Other Lab. Procedures					
Procurement & Handling					

(d) Modernization needs: Determining deficiencies in hospital facilities

For each of the hospitals in the hospital district:
Indicate the extent of any modernization, expansion or replacement projected. If needed work is underway or definitely planned, please indicate this in the discussion. Following is a list of categories to which attention may be given:

> Administration department; central supply; dietary department; employees facilities; laboratory and pathology; laundry and housekeeping; mechanical facilities; nursing units; occupational therapy; pharmacy; physiotherapy; surgery; x-ray and pathology; educational facilities; stairs, corridors, storage rooms, etc.; other.

Based on the JPC's evaluation of this Section ( ), hospital services and facilities appear to be:

a. Adequate ______ c. Inadequate ______

b. Inadequate ______ d. Uncoordinated ______

and priority for further study and action is:

a. High ______ b. Low ______

A. 7 Extended Care Facilities: Auxiliary Hospitals, Nursing Homes, Senior Citizen's Lodges

Introductory Comments and Sources of Information

Extended care facilities are those facilities rendering care to individuals over an extended period of time, where the care does not require the specialized facilities of a general hospital. The major extended care facilities in Alberta are auxiliary hospitals and nursing homes.

An auxiliary hospital is defined (by the Alberta Hospitals Act) as "A hospital for the treatment of long term or chronic illnesses, diseases or infirmities or severe mental disorder". Its patients are usually chronically ill or disabled. Skilled nursing care is provided in auxiliary hospitals, whereas this is not mandatory in nursing homes. In 1975, the average occupancy rate of auxiliary hospitals ranged from a low of 85.88% to a high of 100.59%

The Alberta Nursing Homes Act outlines regulations which are aimed at improving and maintaining high standards of nursing home care. The Act does not define a "nursing home", but does define "nursing home care" as involving the following services:

(1) accommodation, meals and laundry.
(2) personal services, such as help and supervision in cleanliness, mobility, safety, feeding and dressing.
(3) special diets when necessary.
(4) routine drugs and dressings as ordered by the attending physician.
(5) recreational, diversional and re-activational activities, and such other services as are prescribed by the regulations.

Nursing homes may be operated by private individuals under contract with the A.H.S.C. or the board of a hospital district or an auxiliary hospital and nursing home district.

Aged and chronically ill patients can often by cared for adequately in their own homes when community resources are available, such as home visits by public health nurses, meals on wheels programs, home care programs, and satisfactory transfer arrangements with nursing homes or auxiliary hospitals.

Analysis and Interpretation

1) Do adequate facilities exist for the care of the patient needs for extended care?

2) Do extended care facilities have sufficient qualified personnel to provide adequate care and rehabilitation services for patients?

3) Does area-wide health facilities planning encompass extended care facilities?

4) What is the average (mean or median) age of residents in the respective extended care facilities?

5) What is the age range of residents in the extended care facilities: from ______ years to ______ years.

6) What special services are available to the patients in the respective facilities: occupational therapy; physiotherapy; social workers; dietary modifications; chaplain; oxygen therapy; other services (describe).

A. 7 Extended Care Facilities: Auxiliary Hospitals, Nursing Homes, Senior Citizen's Lodges

Local Situation

(a) Identify and quantify, where possible, facilities available for extended care in your area.

Facility	Name or Code	Number Beds	Occupancy Rate	Accred.*		Evaluation		
				Yes	No	A	L	I
1. Auxiliary Hospitals								
2. Nursing Homes								
3. Senior Citizen's Lodges								
4. Day Hospitals								
5. Other								

(A = Adequate L = Limited I = Inadequate)

*Accreditation by the Canadian Council on Hospital Accreditation (CCHA).

(b) Is there a waiting list for admission to extended care facilities:

Yes ______ No ______

If "yes", ascertain how many persons are on each waiting list for admission, and how long the delay is in admission:

(c) Discharged in past year (identify for each facility)

Death ______
Home ______
Hospital ______
Extended care facility ______
Psychiatric hospital ______
Other ______

A. 8 Home Health Care (Comprehensive Home Care Program)

Introductory Comments and Sources of Information

Most patients with long-term illness can be cared for at home providing adequate community health resources are available. Many patients in general hospitals, auxiliary hospitals and nursing homes could be discharged earlier if home care services were available.

A comprehensive home care program is characterized by a centrally administered team approach which provides for coordinated planning, evaluation and follow-up. A home care program should provide medical services (nursing, physiotherapy, occupational therapy, equipment, etc.) and social services (homemaker, friendly visitor, meals on wheels, etc.).

In Alberta, all home care programs are now administered through the public health system. While the number of home care programs are increasing gradually in the province, most smaller communities and rural areas lack home care services. Some that exist serve relatively few patients. Home care services should be available to everyone in need, regardless of economic status. Homemaker and home help services are provided in several communities via the Preventive Social Services program.

The Local Health Services Division, A.S.S. & C.H., has developed guidelines for the implementation of a province-wide system of comprehensive home care programs. At the community level, consumer participation and inter-agency cooperation in the development and operation of a home care program should be encouraged.

Sources of information about home care are: the health units; Preventive Social Service directors; the A.H.S.C.; and the Division of Local Health Services, A.S.S. & C.H.

Analysis and Interpretation

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1) Which geographical areas of the hospital district are served by a home care program?

2) Which types of patients are being served?

3) Which services are provided?

4) What is the method of financing?

5) Hospital relations: list hospitals and nursing homes cooperating with the program. List services provided by them.

6) Discuss extent of participation by physician(s).

7) Is there an advisory group to guide the program? Discuss.

8) What plans are there to expand the size and/or scope of the program in the next twelve months?

9) If the hospital district is being served by more than one comprehensive home care program, what mechanisms exist to coordinate them?

A. 8 Home Health Care (Comprehensive Home Care)

Local Situation

(a) Identify services and programs in the community:

Services	Agency (Codes)	Patients served		Evaluation		
		19__	19__	A	L	I
Coordinated Home Care Program						
Health Surveillance Program						
Home Social Services						
Home Nursing by R.N.'s & C.N.A.'s						
Homemakers/Home help						
Nutrition ("Meals on Wheels")						
Occupational Therapy						
Physio Therapy						
Chiropracy						
Friendly Visitors						
Nurse Registry						
Health Unit or City Health Department						
Other Agencies						
P.S.S.						
Transportation for Handicapped						

(b) Assess the level of coordination and cooperation of the various services being offered:

Based on the JPC's evaluation of this Section (   ), extended care and home health care services appear to be:

a. Adequate ______ c. Inadequate ______

b. Coordinated ______ d. Uncoordinated ______

and priority for further study and action is:

a. High ______ b. Low ______

A. 9 Public Education for Health

Introductory Comments and Sources of Information

Education for health is a fundamental aspect of every community health program. A community health education program should stimulate each individual to maintain good personal health habits throughout life and to participate in community health activities. Maintaining good personal health habits means awareness of the concept of "self-imposed risks".

The educational process must begin with the individual's current level of knowledge and awareness of community health matters, expanding that knowledge and awareness and leading the individual to a decision to act—to participate in the practice and promotion of good health and to refrain from practices that constitute health hazards. To achieve this goal, the educational process must be more than passively informational. It must be effective in shaping public attitudes conducive to constructive action. Public apathy is likely to be as much a problem of lack of motivation as one of ignorance.

The educational aspect of each health program should be recognized and developed as the program itself is being planned. Voluntary and public health agencies, schools, industries, and professional associations should identify and implement educational objectives for improving health services and practices. To some extent, hospitals, health units, medical practitioners, and other health and allied professionals in Alberta have actively participated in the promotion of health education for many years. What has been receiving less attention is the coordination of all health education programs in the community.

As a first step toward such coordination, the JPC might compile an inventory of all health education activities in the hospital district. Once a record is obtained of what educational programs are being carried out, and by whom, it will become possible to discern gaps (if any) in the total health educational effort. Steps to remedy the shortcomings should be taken.

Analysis and Interpretation

1) Often health education is regarded as everybody's business and nobody's specific responsibility. Are there identifiable public (or community) health education programs in the community, specifically staffed with trained specialists in health education?

2) Do these programs focus merely on the use of mass communications media, publicity, and information, or do they also focus on basic health attitudes, motivation, and behavior, particularly among "target" groups within the community?

3) Almost all health-related agencies and organizations have education for health as a primary function. Are these programs being effectively coordinated toward a comprehensive health education program?

4) Is health instruction an integral (not incidental) part of the school health program?

A. 9 Public Education for Health

Local Situation

(a) Identify the programs in the hospital district which are specifically designated as health education in:

(1) Health Unit
(2) General hospitals, auxiliary hospitals and nursing homes, and other facilities.
(3) Schools
(4) The various branches or divisions of the Department of Social Services and Community Health
(5) Voluntary health agencies
(6) Industries
(7) Dentistry
(8) Medical practice (general practitioners)
(9) Other (specify)

What are the felt shortcomings in health education in the hospital district? (Where possible, document the type and focus of the educational program and the number of people reached by the program).

(b) Briefly list and describe health education efforts and results in:

(1) Mass communications

(2) Community organizations

(3) Individual and family motivation

(4) Coordination of education and information services

Based on the JPC's evaluation of this Section ( ), health education services and activities appear to be:

a. Adequate	_____	c. Inadequate	_____
b. Coordinated	_____	d. Uncoordinated	_____

and priority for further study and action is:

a. High	_____	b. Low	_____

A. 10 Nutrition and Exercise

Introductory Comments and Sources of Information

Inadequate nutrition and lack of exercise rank as some of the most important health risks of our society. They contribute to ill-health or detract from optimal health.

The following are considered to fall under the category of "destructive life-style" habits:

(1) over-eating: leading to obesity and its consequences.
(2) high-fat intake: possibly contributing to arteriosclerosis and coronary-artery disease.
(3) high carbohydrate intake: contributing to dental caries.
(4) fad diets: leading to malnutrition.
(5) lack of exercise: aggravating coronary-artery disease, leading to obesity and causing lack of physical fitness.
(6) malnutrition: leading to numerous health problems.
(7) lack of recreation and lack of relief from work and other pressures: associated with stress diseases such as hypertension, coronary-artery disease and peptic ulcers.

In Alberta, a number of government departments employ nutrition resources. The nutrition consultant of the Division of Local Health Services of A.S.S. &C.H. serves all the health units. Alberta Agriculture employs district home economists. The A.H.S.C. employs dietary consultants who serve hospital facilities. The Department of National Health and Welfare employs health promotion consultants. The Department of Consumer and Corporate Affairs provides nutrition-related public information. Some health units employ community health nutritionists.

Analysis and Interpretation

1) Do physicians prescribe dietary modifications?

2) Are physicians and dentists aware of, and do they make use of, the nutrition resources available in the hospital district?

3) Are there sufficient nutrition resources available in the hospital district to provide adequate services?

4) Which health and allied resources are making a concerted effort to emphasize the importance of good nutrition?

5) Are the menus in the various hospitals and in the long-term institutions regularly assessed for nutritional adequacy, pallatibility?

6) Are clients in senior citizen's lodges allowed to eat in their rooms when they wish to do so? Is this encouraged? Discouraged?

7) Are the dietary facilities of the extended care facilities available for use by senior citizens who are served by a meals on wheels program? If not, has this been given serious consideration?

References:

LeRiche, W.H., The Complete Family Book of Nutrition and Meal Planning, Toronto: Home Publishing Ltd., 1976 ($12.95).
Fremes, R. and Z. Sabry, Nutriscore, Agincourt, Ontario: Methuen Publications.
Robertson, E.C., The Right Combination - A Guide to Food and Nutrition, Agincourt, Ontario: Gage Educational Publishing, 1975 ($8.70).

A. 10 Nutrition and Exercise

Local Situation

(a) Nutrition Resources: Identify the personnel serving as resources:

Category	Employing Agency	Evaluation		
		A	L	I
Dietitians				
Dietary Technicians				
Community Health Nutritionists				
Public Health Nurses				
District Home Economists				
Home Ec. & Health Teachers				
Dental Hygienists				
Pediatricians				
YWCA/YMCA				
Other (Specify)				

(b) Nutrition Programs: Identify which exists in the hospital district:

Program or Service	Providing Agency and Jurisdiction code(s)	Evaluation		
		A	L	I
School Lunch Program				
Prenatal Classes				
Family Planning				
Protect Your Heart Program				
E.C.S. Nutrition Program				
Meals on Wheels				
Other (Specify)				

(c) Physical Fitness Resources and Programs: Identify

Resources and Programs	Employing or Providing Agency	Evaluation		
		A	L	I
Recreation Directors				
Phys. Ed. Teachers				
YMCA/YWCA				
Other (Specify)				
Physical Fitness Assessment Program				
Gymnastics Program				
Sport Clubs and Facilities (Specify				

A. 10 Nutrition and Exercise

Local Situation

Based on the JPC's evaluation of this Section (   ), resources and programs in the area of nutrition and exercise appear to be;

a. Adequate ______ c. Inadequate ______

b. Coordinated ______ d. Uncoordinated ______

and priority for further study and action is:

a. High ______ b. Low ______

SECTION B

QUESTIONS ABOUT:

PERSONAL COMMUNITY HEALTH SERVICES

B. 1 Communicable Disease Control

Introductory Comments and Sources of Information

Although much progress has been made, communicable diseases are even now a significant hazard, and, while no longer a major cause of death or illness, they may cause needless suffering and death unless adequate control measures are constantly observed. Infants under one year of age should be protected by immunization against: whooping cough, tetanus, and polio. Immunization against measles should be given at age one. Rubella immunizations should be given to twelve-year-old girls, and, as recommended by the Division of Local Health Services, should also be given to the 15 percent of adult women who are susceptible to rubella, i.e., those working in hospital settings, public health nurses. When 70 - 75% of the population at risk are immunized, "herd" immunity is achieved, and disease is unlikely to spread to epidemic proportion. As the incidence of smallpox in Canada and in many other parts of the world has become extremely low, in Alberta, children are no longer routinely given smallpox immunizations.

Gastrointestinal dieeases transmitted through food, milk, or water may occur as scattered cases or in epidemic proportions. Control activities, including: laboratory tests; isolation, and quarantine; inspection and supervision of food, milk, and water preparation and distribution, are essential elements of a communicable disease control program.

Control programs vary with the needs and conditions in different parts of the Province. Communicable disease control is a primary responsibility of the following divisions of A.S.S. & C.H.: the Division of Local Health Services, the Division of Social Hygiene, and the Tuberculosis Services Division. Effective control programs require cooperative and coordinated efforts with physicians, hospitals, health units, voluntary health agencies, and other institutions and groups.

The effectiveness of communicable disease programs may be gauged by: (1) immunization levels in children, (2) the number of cases and deaths of preventable disease, and (3) absence of disease or epidemics. The divisions listed above provide educational programs and materials for health and allied professionals throughout the Province.

Analysis and Interpretation

1) Were there outbreaks of illness during the past year which resulted in significant absenteeism in schools? In industries?

2) What use is made of infectious disease reports?

3) Are physicians, schools, and hospitals routinely notified of fluctuating incidence of various infectious diseases?

4) What provisions are made for the prevention and control of hospital acquired infections (e.g. staphilococcal)?

5) Is provision made for surveillance of exposed patients after discharge from hospital?

6) What hospitals have cross-infection control committees?

Analysis and Interpretation (Cont.)

7) If there are several hospitals in the hospital district, are there inter-hospital infectious control committees?

References:

The Quarterly Statistical Review (QSR) published by the Research and Planning Division of A.S.S. & C.H. provides a statistical summary and interpretation of the incidence of most communicable diseases by health unit area in the Province. Each Medical Officer of Health has copies of the QSR.

American Public Health Association, Control of Communicable Disease in Man, New York: 1965.

B. 1 Communicable Disease Control

Local Situation

(a) What percentage of the children are protected against the following?*

Disease	% One Year & Under	% When Entering School	Evaluation		
			A	L	I
Diphtheria					
Whooping Cough					
Tetanus					
Polio					
Measles					
Rubella (German Measles) of girls age twelve or over					
Others (Specify)					
T.B. (B.C.G.)**					

(A = Adequate L = Limited I = Inadequate)

*Records of the health unit are a primary source of information.

**The B.C.G. immunization against T.B. is given routinely to Indian and Eskimo newborn babies because these babies constitute a "high risk" group for T.B.

For what disease were epidemiological investigations carried out during the past year?

Food-borne diseases ____________________
Epidemic diarrhea of infants ____________________
Staphylococcal infections ____________________
Typhoid or para-typhoid ____________________
Tuberculosis ____________________
Infectious hepatitis ____________________
Other (specify) ____________________

B. 2 Certain Communicable Diseases

Introductory Comments and Sources of Information

Provincial and Federal laws govern which communicable disease must be reported. In Alberta, communicable diseases which must be notified are first reported to the local Medical Officer of Health, who notifies the Division of Local Health Services of the A.S.S. & C.H., which, in turn, notifies Statistics Canada and reports back to the local Medical Officer of Health on a weekly basis. The system of communicable diseases control in Alberta requires that health units and city health departments immediately notify the Division of Local Health Services regarding all cases in their area. Exceptions to this reporting procedure are: 1) cases of T.B., which are notified directly to the Director of the Tuberculosis Services Division, A.S.S. & C.H. and 2) cases of V.D., which are notified to the Division of Social Hygiene, A.S.S. & C.H.

Regulations regarding notification of communicable diseases are brought to the attention of all general practitioners, hospitals, health units, and other health professionals. It is extremely important that reporting be complete and carried out as a matter of course. Occurrence of even one case of such diseases as diptheria, typhoid fever, or polio may indicate a major lack of communicable disease control methods.

Some problems of communicable disease are illustrated by the following examples: typhoid may be transmitted by polluted water; infectious hepatitis may be transmitted through faulty food handling and services; virus infections, especially German measles, if occurring during pregnancy, may cause congenital defects or even death of the infant.

In most cases of communicable diseases, the person having the disease can be safely isolated or cared for at home or in general hospitals. All hospitals should have up-to-date isolation techniques in order to separate off suspect or proven communicable diseases. For this reason, separate isolation hospitals are rarely justified nowadays. Hospital-acquired infections are a threat which the hospital must continously guard against, as they may quickly become an increasing problem, particularly due to the existence of antibiotic-resistant strains of bacteria such as staphylococcus, and salmonella. Most hospitals have infection control committees responsible for preventing and controlling these problems.

Copies of the regulations regarding communicable diseases may be obtained from the health unit and the Division of Local Health Services, A.S.S. & C.H., Edmonton.

Analysis and Interpretation

B. 2 Certain Communicable Diseases

Local Situation

(a) Indicate the incidence of certain reportable communicable diseases during the past three years:*

Disease	Cases			Evaluation		
	19__	19__	19__	A	L	I
Bacillary dysentary						
Brucellosis						
Chickenpox						
Diphtheria						
Gonorrhea						
Infectious Hepatitis						
Measles						
Polio						
Rabies (in animals)						
Rheumatic fever						
Rubella (German Measles)						
Salmonella						
Streptococcal infections						
Syphilis						
Tetanus						
Tuberculosis						
Typhoid fever						
Whooping cough						
Other (specify)						

*The annual reports of the health unit and the Division of Local Health Services, A.S.S. & C.H. are primary sources of information.

B. 3 Tuberculosis Control

Introductory Comments and Sources of Information

Tuberculosis, although of rare occurrence among the general population, is still a problem of some magnitude (236 new cases of T.B. were reported in Alberta in 1975). Alcoholics, native, older, and very poor people have the highest rates of T.B. The incidence of T.B. among the native population in Alberta is approximately ten times that of the general population. The majority of cases of T.B. are found in Edmonton, Calgary and northern rural Alberta (in 1975, 27.5%, 22%, and 27% respectively). Specially designated hospitals for the treatment of infectious forms of T.B. are located in Alberta (the Aberhart and Charles Camsell Hospitals) and Calgary (the Baker Hospital). The Tuberculosis Services Division, A.S.S. & C.H. provides consultative services to health agents in Alberta. Emphasis is on teaching new concepts of diagnosis and other aspects of tuberculosis control. The Division issues an updated manual for the control and treatment of tuberculosis to providers of care.

Early case finding and adequate treatment offer the patient the best chances for recovery without complications. Home care with drug therapy, following initial hospital care, is an important element of the control program. The cost of care at home is born by A.S.S. & C.H.; affected families requiring additional supportive assistance can obtain this through the regional offices of A.S.S. & C.H. Sometimes patients leave the hospital against medical advice and expose others to infection. Educational measures should be used to prevent their leaving against advice, and restrictive measures having legal sanction should be used only as a last resort.

In Alberta, all children at the grade 1, 5, 9, and 12 level, and all school personnel are tested for T.B. Positive reactors are further investigated with x-ray examination of the chest and examination of all intimate contacts. Tuberculin testing, x-ray examinations of adults in high risk groups, examination of contacts of cases, and laboratory confirmation are essential parts of a case finding program.

Analysis and Interpretation

How many newborn babies have been given B.C.G. immunization against T.B.? To Indian and Eskimo babies only?

B. 3 Tuberculosis Control

Local Situation

(a) High risk groups for T.B. in the hospital district include the following:

(b) Have there been many "positive reactors" during routine testing at the schools in the hospital district?

(c) Ascertain the number of new tuberculosis cases within the hospital district during the past year and indicate where they were treated:

Location	Number
Specially designated hospital for infectious T.B.	
Other Hospitals	
Home, with medical supervision	
Not Treated	
-Discharged against medical advice	
-First reported by death certificate	

Incidence of tuberculosis is (   ), is not (   ), a health concern in the hospital district

B. 4 Venereal Disease Control

Introductory Comments and Sources of Information

Syphilis and gonorrhea, the veneral diseases of major concern in Canada, increased steadily from a low point in the early fifties, to a high point in the year 1970. In Alberta, in 1975, there was a slightly downward trend in the number of reported cases, probably partly reflecting changes in the sexual behavior characteristics of the population. Venereal diseases occur in all levels of society and are communicated by homosexual as well as heterosexual activities. Non-monogamous sexual activity is the main causal factor increasing the level of venereal disease. Its highest prevalence is among the young adult group aged 20-24, followed by those in the age groups 15-19 and 25-29 (1975 data).

Education, early diagnosis and treatment offer the best chance for curing and controlling the spread of these diseases. Examination of known contacts and associates of infected persons probably yields the greatest number of new cases. In Alberta, it is required that blood tests for syphilis be taken before marriage and during pregnancy. Most cases reported are from the health units, the social hygiene clinics (which are found in Edmonton, Calgary, and Lethbridge), the mobile clinics of the Division of Social Hygiene, and the general practitioner. Because some physicians fail to report cases, which is legally obligatory in Alberta, only a partial index of actual incidence is available. In Alberta, the index is probably 95% accurate for syphilis, and approximately 75% for gonorrhea. The Alberta index is more accurate than those of the other provinces in Canada.

Free drugs for treatment and free laboratory examinations are avilable to physicians from the Division of Social Hygiene, A.S.S. & C.H. The general practitioner should treat the patient with symptoms immediately free of charge, regardless of whether the patient is covered by the A.H.C.I.C. The G.P. will be reimbursed by the Division of Social Hygiene if the patient is not covered by A.H.C.I.C. The patient should not have to walk out of the G.P.'s office with a prescription, as this involves the risk of loss of patient treatment.

In Alberta, Nurse Investigators employed by the Division of Social Hygiene investigate VD contact and have the task of tracing the source persons of VD. Information about educational programs, early diagnosis, treatment reimbursements, contact tracing, research, statistics, etc., may be obtained from the Division of Social Hygiene, A.S.S. & C.H., Edmonton.

Analysis and Interpretation

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1) Which professional(s) are involved in the investigation and follow-up program?

2) When positive reports for blood specimens for syphilis and positive smears for gonorrhea are received, are these positive reports followed up to see whether or not they represent cases?

3) Where cases of syphilis or gonorrhea have been diagnosed, what is the average number of contact names (per year) for males and females:
per case of syphilis?
per case of gonorrhea?

4) What percent of contacts have been examined?

Analysis and Interpretation (Cont.)

5) Are there special concentrations of the diseases in racial, ethnic, or cultural groups?

6) Is there special concentration of the diseases in any geographic section of the hospital district?

7) Is there a family life program (including sex education) in the schools?

B. 4 Venereal Disease Control

Local Situation

(a) Indicate the number of reported venereal diseases for the past 3 years:

Disease	Cases			Evaluation		
	19__	19__	19__	A	L	I
Infectious Syphilis						
Gonorrhea						

(b) Identify venereal disease control programs in operation in the hospital district:

Program	Available		Agencies with services	Evaluation		
	Yes	No		A	L	I
Sex education in schools (including VD)						
VD nurse investigators						
Are laboratories in the hospital district diligent in reporting positive results to the Local Health Services Division (A.S.S. & C.H.)?						
Coordination of VD control activities						
Division of Social Hygiene, A.S.S. & C.H.						
Reporting by General Practitioners						
Blood tests required for marriage licence						

(A = Adequate L = Limited I = Inadequate)

B. 5 Diseases of Animal Origin

Introductory Comments and Sources of Information

There are over 100 known diseases which may be transmitted to man by animals. As medical knowledge advances, this number increases. Some are epidemic in nature.

Rabies or hydrophobia, perhaps the most dramatic disease of this type, is usually transmitted in the saliva of rabid carnivores such as dogs, bats, foxes, or skunks. Since many diseases transmitted by animals may be endemic and may remain dormant for long periods in an infected but seemingly healthy animal, outbreaks often occur in previously unsuspected populations. Provisions for prevention, early isolation, and control of such diseases are therefore important, even in communities which are currently free of the problem.

Analysis and Interpretation

1) If there is dairy farming in the hospital district, it is likely that a certain percentage of the population in the district drinks raw milk. Have any health problems arisen from such practices during the past three years?

B. 5 Diseases of Animal Origin

Local Situation

(a) Indicate the incidence in man of diseases of animal origin reported in the last three years in the hospital district:

Diseases	Reported Cases			Evaluation		
	19__	19__	19__	A	L	I
Rabies (Hydrophobia)						
Trichinosis						
Encephalitis (Sleeping Sickness)						
Brucellosis (Undulant fever)						
Psitticosis (Parrot fever)						
Tularemia (Rabit fever)						
Leptospirosis						
Other (Specify)						

(b) Control activities:

(1) Do all the communities in the hospital district require licensing and immunization of dogs? Yes____ No ____

(2) Do all the communities within the hospital district require that all garbage fed to hogs be cooked? Yes____ No ____

(3) Is there a veterinarian readily available to the communities in the hospital district for consultation and epidemiological studies of the animal diseases which are transmissible to man? Yes____ No ____

Based on the JPC's evaluation of this Section (   ), communicable disease control measures appear to be:

a. Adequate ______ c. Inadequate ______

b. Coordinated ______ d. Uncoordinated ______

and priority for further study is:

a. High ______ b. Low ______

B. 6 Chronic Disease Control

Introductory Comments and Sources of Information

The U.S. Commission on Chronic Illness defined chronic illness as follows: "chronic disease comprises all impairments or deviations from normal which have one or more of the following characteristics: are permanent; leave residual disability; are caused by nonreversible pathological actuation; require special training of the patient for rehabilitation; may be expected to require a long period of supervision, observation, or care." Disabling conditions from accidents should be included in this definition.

The dominant public health problems of today are chronic, long-term mental and physical illnesses and disabling conditions. The amount of money and manpower needed to care for these ailments will be staggering unless strong preventive actions are taken. These actions include promotion and maintenance of health; educational measures and procedures to discover diseases in their early stages; provision of prompt treatment before serious or irrevocable damage is done; periodic examinations for early detection of such problems as cancer, heart and lung disease, glaucoma, obesity, dental caries, and periodontal disease.

The laboratory is an invaluable aid in the diagnosis of many other diseases, such as latent syphilis and tuberculosis, before symptoms arise. Screening is the use of one or more simple test procedures for discovering persons likely to have certain chronic illnesses. Blood sugar tests for diabetes, Pap smears for cancer, and glaucoma tests are but some examples. Screening procedures may be carried out through community programs or through physician's offices.

Some screeing procedures should be used for middle-aged or older groups; other procedures, such as vision and hearing tests, are applicable to preschool and school children because a number of chronic diseases begin early in life. Well organized school health services programs find many health defects and potentially disabling conditions in school age children. A special target population in screening for cancer of the cervix is women from 30 - 45 years of age.

Factors predisposing the individual to chronic diseases fall chiefly within two categories: self-imposed risks and the environment. The 1974 Lalonde working document A New Perspective On The Health Of Canadians notes that without changing the environment and reducing the self-imposed risks, the death rates in Canada will not be significantly lowered within the age range 1-70. Self-imposed risks include: alcohol addiction, cigarette smoking, abuse of pharmaceuticals, over-eating, lack of exercise, lack of recreation and lack of relief from work and other pressures, high fat intake, and malnutrition.

Analysis and Interpretation

1) What identifiable programs of primary and secondary prevention of chronic illnesses exist in the hospital district (i.e. to provide for prevention and/or early detection of diseases)?

2) Are existing facilities and services coordinated in operation to provide maximum effective use of each for the patient's benefit, including transfer agreements between facilities or services as patients' needs change?

References: American Public Health Association, Chronic Disease and Rehabilitation - A Program Guide for State and Local Health Agencies, New York, 1960.

B. 6 Chronic Disease Control

Local Situation

(a) Prevention of chronic illness:

Programs	Available		Agency Code(s)	Evaluation		
	Yes	No		A	L	I
Smoking Education						
Weight Control Education						
Periodic Health Appraisal						
Other						

(b) Detection (screening) programs:

Program	Number screened			Program Sponsor	Evaluation		
	Pre-school	School-aged	Adult		A	L	I
Cancer of Cervix							
Chronic Respiratory Disease							
Diabetes							
Glaucoma							
Hearing Defects							
Periodic Health Appraisal							
Tuberculosis							
Vision Defects							
Hypertension							
Kidney Disease							
Other							

(c) Which health professionals do follow-up for diagnosis and treatment of the various chronic diseases?

(d) Which professionals in the hospital district are involved in the coordination of chronic disease control activities?

Based on the JPC's evaluation of this Section ( ), chronic disease programs appear to be:

a. Adequate ______ c. Inadequate ______

b. Coordinated ______ d. Uncoordinated ______

and priority for further study and action is:

a. High ______ b. Low ______

B. 7 Dental Health Services

Introductory Comments and Sources of Information

Dental decay is the commonest of man's diseases. It affects our general health and well-being from infancy to old age and is especially hazardous in the vital years of growth and development. Each individual must carry out his own dental decay prevention program. Dental health is important to one's appearance, sense of well-being, general health and ability to eat a variety of foods.

There are several things which individuals and communities can do to prevent tooth decay. These preventive measures also contribute to the prevention and control of malocclusion (crooked teeth) and periodontal conditions (gum diseases).

The most effective preventive measure for dental caries is the regular intake of fluoride in sufficient quantity. Accumulated scientific evidence has demonstrated convincingly that children using a water supply containing a minimum of 1.0 parts per million of fluoride from birth have 60-65% less tooth decay than children drinking water with no fluoride. This reduction in dental decay is carried into adult life. In many areas, fluoride occurs naturally in drinking water, but usually not in sufficient quantity to prevent tooth decay.

For children, the application of fluorides directly to the teeth is accepted as a method of preventing tooth decay. Fluoride-containing dentrifices, while helping to clean teeth, are an adjunct to and not a substitution for fluoridated water and topical application of fluorides. Daily flossing is another important preventive measure.

Since most children of school age need annual dental care, all children should be seen by their family dentist, or by personnel of the dental health program of the health unit (in 1976, all Alberta health units except two employed a full-time dental hygienist). Financial assistance should be available for those unable to afford care. The regional office of A.S.S. & C.H. can provide information regarding eligibility for financial assistance to cover dental expenses. Information about the number of children who have been provided a dental service by the Dental Health Program of the local Health Unit may be obtained from the Health Unit's quarterly and annual reports, (i.e., how many children were eligible, examined, treated, given instruction in flossing, or received fluoride treatment.) Schools should include dental health in their regular health education program.

Unfortunately, there are still many parents who do not realize that baby teeth need care to prevent decay and misalignment of permanent teeth which begin to erupt at about age six. Delay of care, at all ages, leads to more expensive care later, premature loss of teeth, and denture expenses.

The optimum ratio of dental hygienists is 1 per 2,400 population; of dental officers, it is 1 per 50,000 population.

Analysis and Interpretation

The dental officer or dental hygienist working with the local health unit might be approached for information about the number of schools visited by the dental health program, the percentage of pre-school and school children who were seen, examined, treated, etc.

Analysis and Interpretation (Cont.)

The dental officer and other local dentists in private practice might be approached with a view to ascertaining if there have been important changes in the amount of dental decay found among children over the past few years.

Do all schools have a dental health component in their health education program? Is it adequate? How might it be improved?

An estimate of the number of people requesting and/or receiving financial assistance to cover dental costs may be obtained from the regional office of A.S.S. & C.H.

B. 7 Dental Health Services

Local Situation

(a) Identify selected dental health services:

Program	% Population involved (or number)	% or number of pre-school children involv.	% or number of school children involved	Agency Code(s)	Evaluation		
					A	L	I
Inspection							
Referrals to family dentist							
Topical application of fluorides							
Dental Education in schools:							
1. Counselling child/parent							
2. Oral Fluoride Program							
3. Others: (Specify)							
Others:							

(A = Adequate L = Limited I = Inadequate)

(b) Are all public water supplies within the hospital district adjusted for proper fluoride content? (1-1.6 ppm) Yes ____ No ____

(c) Do all dentists in private practice in the hospital district actively promote dental health education in their clinics?

Based on the JPC's evaluation of this Section ( ), dental health services appear to be:

a. Adequate ____ c. Inadequate ____

b. Coordinated ____ d. Uncoordinated ____

and priority for further study and action is:

a. High ____ b. Low ____

B. 8 Mental Health

Introductory Comments and Sources of Information

Psychiatric disorders have many causes. The causes are often grouped under the two main headings of precipitating and predisposing factors. Some predisposing factors are: hereditary factors, childhood experiences (e.g. excessive frustraction, or, less commonly, excessive gratification of basic needs) and sexuality factors (such as the development of immature attitudes towards sex). Precipitating factors may be subdivided into physical and psychological factors. Physical precipitating factors include brain injury, brain disease, toxic factors, bodily illnesses. Psychological precipitating factors include the special stresses associated with the "critical" life periods of adolescence, middle age, and old age, marriage and parenthood, occupational stresses, and bereavement. The factors listed are by no means exhaustive but provide an orientation to the complexities involved in the causation of mental illnesses.

Other conditions associated with mental illnesses include: high child delinquency rates, high illigitimacy rates, high divorce rates, alcoholism, and certain social deprivations, such as poor housing and low socio-economic status.

Every community needs access to community mental health services which are comprehensive, which provide continuous coordinated care, and which are integrated into the total community health services. Mental health services should include:

1. promotion of mental health
2. early family counseling
3. school mental health services
4. child guidance service
5. adult clinics
6. psychiatric inpatient services in general hospitals
7. emergency care facilities
8. long-term institutional care
9. qualified psychiatric professionals such as psychiatrists, clinical psychologists, psychiatric social workers, psychiatric nurses, (and general nurses trained in psychiatric nursing)
10. follow-up of patients discharged from the psychiatric hospitals, or the psychiatric wards of the general hospitals.
11. comprehensive services for the alcoholic
12. cooperation of the police, courts, probation welfare authorities, teachers, clergy, and others.

While some components will not be found in smaller communities they should be available in sufficient quantity at accessible nearby facilities. Family physicians, clergy, public health nurses, and counselling agencies are in the front line of the attack on mental illness.

Drug addiction is often closely associated with emotional problems and may be a serious problem. Both A.A.D.A.C. and Alberta Mental Health Services have a primary responsibility for this problem.

Increased attention is being given to prevention of suicides in Alberta (a task force was set up in 1974). In larger communities it might be feasible to have a suicide prevention facility, which might be connected to a hospital. In most Alberta communities there is no special suicide facility, and the local hospital often serves as the facility for

Introductory Comments and Sources of Information

treating the suicidal patient. In the larger cities there are distress telephone services which provide assistance to the suicidal individual on a 24 hour basis.

Analysis and Interpretation

Questions about mental health needs and services in the hospital district may be interpreted from the standpoint of the following considerations:

1) Are services and facilities for the care of (diagnosing, treating, rehabilitating) the emotionally disturbed and mentally ill adequate to meet the needs of patients and their families?

2) Are preventive and educational programs sufficient in scope and effectiveness to influence prevalence of disease and to ensure a positive response to needs?

3) Are the agencies and organizations working together collaboratively to deal with mental health problems (e.g., police, schools, courts, social agencies, public health unit), thereby making for a coordinated approach to solving mental health needs throughout the hospital district?

B. 8 Mental Health

Local Situation

(a) Identify services and agency programs relating to mental illness:

Services	Agencies Providing Services (Codes)	Evaluation		
		A	L	I
Education				
Counselling				
Early case-finding				
Treatment				
After-care				
Coordination/planning				
Suicide Prevention				
Other				

(b) Identify facilities for the care of the mentally ill within the hospital district, and within the Alberta Mental Health Region:

Facilities	Agency or Institution Codes	Admission waiting time (wks)	Evaluation		
			A	L	I
1. In-patient emergency					
Short term care					
Half-way houses					
Rehabilitation					
Day-hospital					
Other					
2. Out-patient clinics					
Home follow-up					
Group therapy					
Lifeline program					
Coordination					
Other					

B. 8 Mental Health

Local Situation

(c) Identify programs which involve other agencies in mental health activities:

Group	Specific Programs	Evaluation		
		A	L	I
Clergy				
Courts				
Canadian Mental Health Assn.				
Police				
Schools				
Welfare/social services				
General Practitioners				
Family Guidance Clinics				
Other				

(d) Are services and facilities available for:

1) Children and adults Yes ______ No ______

(e) Do around-the-clock suicide prevention services and/or facilities exist within the hospital district? Yes ______ No ______
If "yes", specify what kind of service or facility:

Based on the JPC's evaluation of this Section (   ), mental health services and/or facilities appear to be:

a. Adequate ______ c. Inadequate ______

b. Coordinated ______ d. Uncoordinated ______

and priority for further study and action is:

a. High ______ b. Low ______

B. 9 Alcoholism and Drug Addiction

Introductory Comments and Sources of Information

Alcoholism is a chronic illness which manifests itself as a behavioral disorder. A useful working definition of the alcoholic is: any person whose drinking repeatedly interferes with his family relationships, general welfare, health, or job. The Canada rate for alcoholics has been estimated at 300,000. Estimates are that less than ten percent of alcohol users (between 2 to 5%) are in the "skid row" category; 78% are performing skilled work or better; and 11% are professional or managerial personnel.

The community approach requires education about the disease. Community services include outpatient counselling and rehabilitation services and facilities for the alcoholics and their families. Cooperation with the local unit of Alcoholics Anonymous is desirable. The Alberta Alocholism and Drug Abuse Commission (A.A.D.A.C.) has primary responsibility for the prevention, treatment, and rehabilitation of alcoholism and drug abuse. A.A.D.A.C. has available many educational materials and programs for prevention of alcoholism.

Drug addiction and drug dependence are conditions in which a person compulsively and repetitively abuses a drug to the extent that it harms the individual and society. Many types of drugs are commonly abused, such as benzedrine, mescaline, opium and its derivative (e.g., heroin, morphine, and cocaine), bromides, barbiturates, and marijuana. The severity of physiological and/or psychological withdrawal symptoms is often related to the severity and type of treatment. There are related problems in the general drug dependence area, such as those pertaining to LSD and solvent ("glue") sniffing, for which preventive and therapeutic services should be available.

The burden of addiction control falls not only upon the individual and his family, but also on police, courts, hospitals, social services, education, and other agencies serving the community.

Analysis and Interpretation

The services of A.A.D.A.C. are organized on a regional basis. The five regions are: Edmonton, Calgary, Red Deer, Lethbridge, and the Northern Region. The regional offices can furnish detailed information about A.A.D.A.C. activities.

1) Is alcoholism recognized as a problem in the hospital district?

2) Are there organized units of Alcoholics Anonymous in the hospital district?

3) Are the local educational programs which are now organized in the hospital district effective in increasing the awareness of alcoholism problems and community attempts at reducing them?

4) Are community facilities and services adequate to treat and rehabilitate alcoholic patients needing specialized care?

References:

World Health Organization, "Addiction-Producing Drugs," Technical Report Series 273, 13th Report of the Expert Committee, Geneva, 1964.
1973 Canada: Commission of Inquiry into the Non-Medical Use of Drugs. (Le Dain Commission) Final Report. Ottawa: Information Canada.

B. 9 Alcoholism and Drug Addiction

Local Situation

(a) Alcoholism - Identify services and agency programs:

Service	Agency Code(s)	Facility	Evaluation		
			A	L	I
Education					
In-patient					
Counselling					
Case-finding					
Treatment					
After-care/follow-up					
Rehabilitation					
Employment					
Home follow-up					
Clinics					
Crisis Center					
Family Services					
Other					

Do individuals who are alcoholics or have an alcohol problem encounter a waiting time for alcoholism services?

(1) Out-patient clinics ______ weeks
(2) Institutional care ______ weeks

(b) Drug Addiction - Identify services and agency programs:

Service	Agency Code(s)	Facility	Evaluation		
			A	L	I
Education					
In-patient					
Counselling					
Case-finding					
Treatment					
After-care					
Rehabilitation					
Employment					
Home follow-up					
Clinics					
Crisis Center					
Other					

Is there a waiting time for service or care? (Specify as under alcoholism.)

Based on the JPC's evaluation of this Section (   ), services for alcoholism and drug addiction within the hospital district appear to be:

a. Adequate ______
c. Inadequate ______
b. Coordinated ______
d. Uncoordinated ______

and priority for further study and action is:

a. High ______
b. Low ______

B. 10 Mental Retardation

Introductory Comments and Sources of Information

A mentally retarded person is someone who shows impairment in intellectual functioning or capacity. A retarded child for example, has difficulty learning; at maturity his capacity to understand will be less than normal. Over 200 causes have been identified but it is often difficult or impossible to determine the cause in a given case. Mental retardation can occur in families rich and poor, learned and uneducated.

Factors important in preventing the occurrence of mental retardation include genetic counselling; prompt and vigorous treatment of infections in pregnancy; elimination of self-medication of the mother during pregnancy; judicious use of radiation; early and continuous prenatal care; and good nutrition. Testing for Phenylketonuria (PKU) is a very important preventive measure. In Alberta, all babies are routinely tested for PKU.

Mental retardation is neither an illness nor a disease. It is a life-long condition. However, there are conditions sometimes related to mental retardation which can be improved or cured. For instance, deafness, poor vision, emotional disturbance, or poor living conditions may make a child appear to be retarded.

In terms of magnitude, mental retardation is one of the most handicapping of all disorders. Three out of every 100 children are mentally retarded to some degree -- which means that in Alberta it is estimated that there are approximately 49,000 mentally retarded persons. Eighty-eight percent are mildly retarded. With early and proper teaching this group can succeed in some school work and can be taught to be reasonably self-supportive adults. Seven percent are moderately retarded, but with suitable schools and work training centers they can be self-supporting to some degree. Four percent are severely retarded, and one percent are profoundly retarded and may need life-long nursing care.

In Alberta, the Services for the Handicapped Division (S.F.H.) of A.S.S. & C.H. has a primary responsibility for the provision of services to the mentally retarded. An even more important aspect of the work of the S.F.H. is that of encouraging the development of local community resources for the mentally retarded. The S.F.H. can provide resources, consultation and funding to community groups concerned with service needs for the mentally handicapped. The Alberta Association for the Mentally Retarded provides educational materials and other services about and for the mentally retarded (the Association's office is located in Edmonton).

B. 10 Mental Retardation

Local Situation

(a) Identify services for mentally retarded in the community:

Services	Agency Code(s)	Evaluation		
		A	L	I
Day care				
Diagnostic				
Foster home placement				
Public School programs				
Recreational				
Rehabilitation				
Early Childhood services				
Work training programs				
Work stations within industry				
Residence for adults				
Residence training program				
Sheltered workshop				
Public School programs				
Babysitting and/or relief programs				
Public education				
Other				

(b) Do all hospitals perform blood tests to detect PKU on all infants before they are discharged from hospital? Yes ______ No ______

(c) Does each school in the hospital district have access to special education programs for:

(1) Slow learners? Yes ______ No ______
(2) Educable retarded? Yes ______ No ______
(3) Trainable retarded? Yes ______ No ______

(d) What is the current waiting period before a mentally retarded individual can be admitted for institutional care?

(e) How many on the waiting list could be cared for at home if facilities listed above were adequate?

B. 10 Mental Retardation

Local Situation

(f) Identify voluntary organizations concerned with mental retardation and the nature of their programs:

Organization (Name)	Nature of Program (Code)*	Evaluation		
		A	L	I

*Code 1. - Family counselling
2. - Support classes for MR
3. - Promotes community action (or public education)
4. - Professional guidance
5. - Sheltered workshop
6. - Coordinate programs, other agencies

Based on the JPC's evaluation of this Section (   ), services for the mentally retarded in the hospital district appear to be:

a. Adequate ______
b. Coordinated ______
c. Inadequate ______
d. Uncoordinated ______

and priority for further study and action is:

a. High ______
b. Low ______

B. 11 Handicapped Children

Introductory Comments and Sources of Information

Every community is concerned about preventing conditions that will handicap a child in achieving his/her potential physical, emotional, and intellectual development. For those conditions that are not preventable, it is important that they be detected as early in life as possible in order that corrective steps may be taken.

Early case-finding of congenital malformations depends on diligent examinations by physicians and other hospital staff. For example, defects of vision and hearing may be detected by examining physicians in private practice, by public health nurses in well-baby clinics or through screening of pre-school and school children. Non-organic speech defects may be related to family conflict and may respond quickly to treatment if the underlying problem is identified. In general, the earlier a defect is recognized the more likely it can be helped by treatment.

If the defect cannot be eliminated or reduced by treatment, early detection is still important in order that the child may be helped to adjust to the defect and may have the benefit of artificial appliances, hearing and vision aids, speech therapy, and special education to reduce the net defect on development and education. The emotional problems of a child with a physical handicap may be severe and perplexing to parents. Educational programs and counselling services for parents, plus the socialization of the child through group recreational programs may help the child to achieve a good adjustment to the handicap. The Medical Services Division of A.S.S. & C.H. operates an educational division from which information about handicaps and resources may be obtained.

The variedness and complexity of the problems and needs of the handicapped child call for the mobilization of the many resources available in Alberta. These resources comprise a number of divisions of A.S.S. & C.H., and many other governmental and non-governmental agencies and organizations.

In Alberta, the Medical Services Division operates a number of programs related to handicapped children. These include the Registry for Handicapped Children and Adults; the Cleft Palate Program, which operates two cleft palate clinics in the Province (the Cleft Palate Clinic in Edmonton is located in the University Hospital, the Calgary Clinic is located in the Children's Hospital); the Polio Service; a Drugs Program for special groups (e.g., Cystic Fibrosis); Diabetic Program; P.K.U. Program; Ostomy Program; the Juvenile Amputee Program; the Multiple Handicapped Children's Program.

All general practitioners in Alberta receive information from the Health Services Division regarding the programs and services offered by the Division.

Analysis and Interpretation

B. 11 Handicapped Children

Local Situation

(a) Services by Voluntary and Official Agencies, Hospitals, and other Organizations.

Type of Handicap	Case Finding	Information and Referral	Diagnostic	Physical Restoration treatment	Appliances, Aids	Speech Therapy	Special Education	Parent Counselling	Recreation	Special Transportation	Long Term Institutional	Financial Assistance
Burns												
Cerebral Palsy												
Epilepsy												
Heart												
Poliomyelitis												
Congenital Malformations												
Orthopedic												
Cleft palate/lip												
Malocclusion												
Speech, Non-organic												
Visual												
Hearing												
Mental Retardation												
Other												

Enter the agency code in the blocks signifying the services rendered by each agency. The agencies will include branches of A.S.S. & C.H., and other departments of the provincial government; hospitals, rehabilitation centers, and special institutions; several health agencies, and service clubs.

When the chart has been completed, examine it for "open" blocks which, in some instances, may signify a service that is needed but not available.

B. 12 Handicapped Adults - Rehabilitation Services

Introductory Comments and Sources of Information

The same general principles apply to services to handicapped adults as to children except that emphasis on special education and parent counselling is replaced by vocational counselling and training, sheltered workshops and job placement. On other pages of the ACHSSO, the detection of handicapped conditions and the special rehabilitation problems associated with mental illness, addiction, mental retardation and aging are dealt with. The section is concerned chiefly with the general rehabilitation services provided to handicapped adults.

Although there is some overlapping, rehabilitation services can be divided into those that are medically oriented and seek to restore maximum physical function; and those that are vocationally oriented and seek, by special training, special equipment, and selective job placement, to rehabilitate the individual in spite of his residual handicap.

These resources include: the Workers Compensation Board; the federal department of manpower and immigration; the Vocational Rehabilitation Branch of A.S.S. & C.H.; and the Department of Advanced Education and Manpower.

Services which are generic to all handicapped people (including the mentally and intellectually handicapped) include: 1) activities centres; 2) vocational training centres; and 3) vocational rehabilitation centres (located in Edmonton and Calgary). There are over ninety "placement" services in Alberta operated by agencies, or private businesses. The Division of Career Development, Department of Advanced Education and Manpower, provides on-the-job training for handicapped persons experiencing difficulty in obtaining and retaining work because of their handicap.

The Alberta Rehabilitation Council for the Disabled (for address see Edmonton AID directory) offers a variety of rehabilitation programs and other services for the disabled. Handicapped persons wishing to seek training in a standard facility (i.e. NAIT; SAIT; A.V.C.'s) are eligible for financial support under the Vocational Rehabilitation of Disabled Persons Agreement (V.R.D.P.). The same applies to handicapped persons seeking training in special institutes for training, such as vocational training centres.

Analysis and Interpretation

B. 12 Handicapped Adults - Rehabilitation Services

Local Situation

(a) Rehabilitation Centers

(1) Does the hospital district have at least one comprehensive* vocational training center? Yes ______ No ______
If yes, what are the written entrance and exit requirements?

(2) If "yes", does the center operate at full capacity ______? below capacity ______? with a waiting list ______?

(b) Vocational Training Centers and Activities Centers

(1) Are there any centers in the hospital district that:

(1) Provide vocational training for handicapped workers? Yes ______ No ______

(2) Provide long-term sheltered employment? Yes ______ No ______

(3) Do rehabilitation counsellors regard these workshops as adequate to meet the need? Yes ______ No ______

(c) Employment

(1) Is there an association or group in the hospital district to encourage the employment of handicapped persons in the community(ies)?

(2) Does the local Canada Manpower Center and other placement services (e.g., occupational therapists) report difficulty in finding jobs for clients who have had adequate physical restoration and retraining? Yes ______ No ______

(d) Agency Relationships

(1) What are the principal sources of referral to the Vocational Rehabilitation Services?

(2) What percentage of the cases are accepted? ______%

(3) What are the principal reasons for not accepting a referral for service?

(4) Does the local regional office of A.S.S. & C.H. have an effective referral relationship with rehabilitation agencies? Yes ______ No ______

(e) Other comments or observations:

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*Comprehensive means here that the center provides services to all handicapped people (physically, mentally, intellectually).

B. 13 Family Planning

Introductory Comments and Sources of Information

Family planning may be defined as the process of the personal management of reproduction, in all its aspects. The decisions of whether or not to have children, when to have them, how many to have, and how to care for and support them are basic to family planning.

The goal of family planning is to assist the family in achieving the number of children desired, with appropriate spacing and timing to ensure the optimal growth and development of each family member. Health benefits of family planning are many, and include the following:

(a) family size and birth intervals: "perinatal, neonatal, infant and maternal mortality, and stillbirth all increase after the fourth birth. Optimal birth intervals can be planned and can increase the health and safety of another child.

(b) unwanted birth: their reduction is probably the most important goal of family planning.

(c) maternal age: this variable has a profound effect on fetal deaths, and perinatal and infant mortality. Very young mothers and mothers over thirty-five expose themselves and their offspring to greater risks.

(d) illegal abortion: affects the rate of abortion-related maternal death. Legalization of abortion reduces the nonseptic abortion ratio.

(e) genetic disease, fertility enhancement and sexual dysfunction: family planning counselling plays an important role in these areas of concern.

Family planning services should include the provision of information, education, and medical services, as well as counselling and referral. The three primary sources of family planning services in Alberta are physicians, private organizations and the public health system. The Family Planning Program of the Division of Local Health Services, A.S.S. & C.H., provides consultation, educational and information services to family planning resources in the Province. Its other roles are to encourage communication and cooperation between all providers of family planning services, and to raise the levels of awareness and knowledge among helping professionals and the general public about family planning issues.

Analysis and Interpretation

1) Which agencies in the hospital district are actively involved in providing family planning information in the hospital district?

2) What is their target population?

3) Is there adequate consultation and coordination among the providers of family planning services?

B. Family Planning

Local Situation

(a) Identify the providers of family planning services in the hospital district:

Resources	Agency or Person(s) responsible and jurisd. code	Evaluation		
		A	L	I
Physicians General Practitioner Specialist				
Private Association				
Health Unit				
School counsellor				
Other (Specify)				

(b) Identify the family planning programs existing or being developed for the hospital district, and specify who provides the service:

Program or Service	Providing Agency	Evaluation		
		A	L	I
Information				
Education				
Special Clinics Workshops/Seminars				
Films and Literature				
Therapeutic Abortion				
Rape Awareness				
Other (Specify)				

Based on the JPC's evaluation of this Section ( ), family planning resources and programs/services appear to be:

a. Adequate ______ c. Inadequate ______

b. Coordinated ______ d. Uncoordinated ______

and priority for further study and action is:

a. High ______ b. Low ______

B. 14 Health Needs of Infants and Parents

Introductory Comments and Sources of Information

In Alberta, nearly all births in a hospital are attended by a physician. Women should receive continuing prenatal care beginning as soon as pregnancy is realized or suspected. Pre-natal classes are operated by health units, hospitals, and medical clinics.

Prematurity, one of the leading causes of infant death may be reduced by adequate prenatal care. Public health nurses and physicians may assist families to find access to both pre- and post-partum care. Special hospital services and home arrangements are (may be) required for premature infants. In Alberta, it is common practice to keep the baby in hospital until he/she weighs at least five pounds.

Adequate child health supervision includes periodic medical examination of the infant, immunizations, assessment of nutritional status, and counselling parents regarding the infant's growth and development. In Alberta, these and other aspects of child health supervision are provided chiefly by the health units.

Proper spacing of children is important for the health of both the mother and her children. Family planning services may be offered by the health unit personnel, voluntary organizations (such as the Alberta Family Planning Association), and physicians.

Analysis and Interpretation

1) Are women receiving adequate prenatal care early in their pregnancy? Do expectant fathers participate in prenatal training?

2) How many babies were born to unwed women during the past year? How does this rate compare with the provincial average?

3) What is the proportion of "low birth weight" or premature births of total births in the hospital district? Compare this result with the rate for Alberta.

4) Is there a follow-up program for low weight babies?

5) Based on the informed judgment of the JPC;

Are programs adequate to meet the needs? If not, what are the deficiencies? What are the reasons for them?

Are sufficient personnel available to provide a desirable program? If the answer is no, what additional personnel are needed, by job category?

B. 14 Health Needs of Infants and Parents

Local Situation

(a) What is the trend in delivery care in your community as indicated by percent of deliveries in hospitals over the past decade?

196_ ______ 196_ ______ 197_ ______ (Enter hospital births)

(b) Compare the trend of infant and maternal mortality rates over the past decade in the hospital district with those of Alberta and of Canada.

	Death Rates					
	19__			19__ (latest year)		
Deaths	Community Hosp. District	Alta.	Can.	Hosp. District	Alta.	Can.
Infant deaths*						
Stillborn						
Neonatal (under 1 mo.)						
Infant (under 1 year)						
Maternal deaths**						

*Rate per 1,000 live births
**Rate per 100,000 live births

(c) Identify selected services available for infants and mothers:

Services	Agency(ies) Providing Service (Codes)	Evaluation		
		A	L	I
Pre-natal care				
Post-natal care				
Delivery service				
Care of prematures				
Well-child conferences				
Family planning				
Other				

(A = Adequate L = Limited I = Inadequate)

Based on the JPC's evaluation of this Section ( ), services for infants and mothers appear to be:

a. Adequate ______ c. Inadequate ______
b. Coordinated ______ d. Uncoordinated ______

B. 15 Health Needs of Pre-School Aged Children

Introductory Comments and Sources of Information

In Alberta, the pre-school years are no longer, at least for the majority, the negligent years of health supervision and care for children. In this age group, accidents are the leading cause of death.

Disturbances in growth and in social, emotional, physical, and intellectual development may produce life-long defects or disabilities. Pre-schoolers need periodic examinations by the physician, the public health nurse, and the dentist. Agencies and organizations providing services for children in this age group include the health unit, day care services, early childhood programs, child guidance clinics.

The increased percentage of mothers of young children in the labor force makes it important that adequate, well-supervised day care facilities be available for their children, and that day care center personnel be knowledgeable about child development, in addition to being able to work well with pre-school children.

Day care centers oriented toward the two to five year-old group have sprung up in many communities during the past few years. Cost sharing arrangements for the building and operation of day care centers between community groups, such as parent co-ops, day care societies, and other organizations, and the provincial government (i.e. through P.S.S. funding) have stimulated the development of day care centers. Many school boards (particularly those in the larger communities) operate early childhood services (E.C.S.) programs. The Preventive Social Services (P.S.S.) Branch of A.S.S. & C.H. is a primary source of information about the requirements for establishing day care centers. Information regarding E.C.S. programs may be obtained from the Department of Education. These programs provide a learning experience (in a classroom situation) for children aged 4½ to 5½ years under the supervision of an Alberta-certified teacher.

Analysis and Interpretation

1) Is child neglect or child battering a problem in the community?

2) Is there a satisfactory working relationship between staff members of the health unit and those of the day care center?

B. 15 Health Needs of Pre-School Aged Children

Local Situation

(a) Identify services available to the pre-school child:

The quarterly and annual reports of the health unit are the primary sources of information regarding periodic examination, immunizations, and screening.

Services	Agencies Providing Services	Evaluation		
		A	L	I
Periodic Health Examinations				
Initial Immunizations*				
Booster Immunizations*				
Dental Examinations				
Guidance Clinic				
Early Childhood Services				
Day Care Center				
Hearing Screening				
Vision Screening				
Denver Psychological Testing				
School Lunch Program				
Other (Specify)				

*For the 5 basic communicable diseases (Diphtheria, Whooping Cough, Tetanus, Polio, Measles)

(A = Adequate L = Limited I = Inadequate)

Based on the JPC's evaluation of this section ( ), overall services for the pre-school child appear to be:

a. Adequate ______ c. Inadequate ______

b. Coordinated ______ d. Uncoordinated ______

and priority for further study and action is:

a. High ______ b. Low ______

B. 16 Health Needs of School-Aged Children

Introductory Comments and Sources of Information

Health services in the schools are provided by the school system (either public or private) and the personnel of the health unit. Parents have the primary responsibility for periodic medical and dental examinations and care, but the schools, health units and other community agencies should supplement and reinforce the efforts of parents (if necessary).

The nurses of the health unit furnish periodic examinations of children. Most children in Alberta are given a comprehensive "school beginners' examination" when entering school for the first time. These examinations often identify particular physical and emotional health problems. Teachers and public health nurses should confer periodically regarding the health of each child and may refer children for evaluation and follow-up. Conferences between the nurses and parents should be held when indicated.

Public health nurses should be involved in various health education programs in the schools. For example, health films could be shown and talks related to such topics as nutrition, general health and hygiene could be given. Further, the nurses could provide counselling on emotional development and physical growth.

Classroom health education is the school's responsibility as is the provision of a safe and healthful environment including safe water supply, proper sewage disposal, adequate hand-washing facilities, proper heating and lighting, safe food handling, safe recreation facilities, and safety programs on the way to and from school.

Since school children spend only part of their time in school it is important that school health services are coordinated with other community health services, such as those provided by the Health Unit and the given practitioner. First-aid should be given by teachers or other personnel who have had adequate training.

Special emotional and adjustment problems should not be overlooked, including problems of venereal disease and pregnancy in this age group. Many school systems employ school-counsellors to provide assessments of learning disabilities and emotional and adjustment problems. The Family Service Clinics, of the Division of Mental Health Services, A.S.S. & C.H., also provide a health service to school children often involving the family in the treatment process as well.

Analysis and Interpretation

1) Is health education, taught by teachers specializing in the subject, an integral part of the school's curriculum?

2) Are adequate health services available to all students (including immunization, screening, diagnosis, treatment, referral and rehabilitation)?

3) Are school health programs and services functionally coordinated with those of other community health agencies offering services to students and their families?

B. 16 Health Needs of School-Aged Children

Local Situation

(a) List health services provided for school children:

Services	In All Schools		In Some Schools		In no Schools	Elsewhere in Hosp. D.	Evaluation		
	Yes	No	Yes	No			A	L	I
Physical exam - routinely									
-only if requested by school									
Dental check-up									
Immunizations									
Vision Screening Tests									
Hearing screening									
Follow-up for defects									
Cumulative health records									
Periodic exam (School personnel)									
First-aid									
Accident prevention									
Safety in competitive sports									
Insurance for athletes									
Health education									
Physical fitness program									
Coordination of school health program									
School lunch program									
Other (Specify)									

(b) Identify specific schools which do not make these services available?

(c) Identify health services for children of school age which are not provided in the entire community/hospital district:

Based on the JPC's evaluation of this section (   ), health services provided children of school age appear to be:*

a. Adequate ______
b. Coordinated ______
c. Inadequate ______
d. Uncoordinated ______

*If health services for some schools of the hospital district are adequate but not for others, specify which schools.

B. 17 Health Needs of the Aging

Introductory Comments and Sources of Information

Persons over 65 years of age have more illness, greater disability, and often fewer resources than do persons in younger age groups. Hospitalization is more frequent and extends for longer periods of time. Many elderly, especially those aged 75 and over, have one or more chronic illnesses which may cause some disability. Cardiovascular diseases, including strokes, require intensive care, frequently in general and extended care hospitals and nursing homes.

Much of the disability experienced in later life results from conditions which began in childhood, adolesence, or early adult and middle-age life. Periodic and multiple screening programs may identify departures from good health and can lead to early initiation of therapeutic care.

Health and social problems of the aged have received increasing attention from the provincial government in recent years. The Senior Citizens Division, A.S.S. & C.H., was established in 1975. Its mandate is to act as an information center, to coordinate provincial programs for the aged, to assist in planning new programs, and to serve as a resource to the Provincial Senior Citizens Advisory Council. The Alberta Council on Aging is a province-wide organization which actively promotes the interests of the elderly.

At the community level, the health and social services which meet the needs of the elderly include home care, homemaker and home help, meals on wheels, and drop-in centers. As the percentage of elderly persons continues to increase it is important that community-based services be developed to enable the older person to live with dignity in his own home for as long as possible. It is suggested that the JPC involve the elderly in making an assessment of the adequacy of health services for the aged.

Analysis and Interpretation

1) Is there a local council on aging in the hospital district?

2) Are there drop-in centers? Do these centers provide "outreach" services?

3) Are community health services meeting the needs of the elderly?

4) Do the elderly have transportation problems?

References

Department of Social Services and Community Health, Senior Citizens in Alberta: A Position Paper, 1975.

Department of Social Services and Community Health, Programs and Services for Senior Citizens in Alberta, January, 1975.

B. 17 Health Needs of the Aging

Local Situation

(a) Identify selected community services for the aging:

Service	Program Identification	Evaluation		
		A	L	I
Pre-retirement Counselling				
Recreation				
Medical Clinics				
Health Benefits (e.g. free glasses)				
Health Counselling				
Drop-in and Social Activity Centers				
Employment Programs				
Home Support Services, e.g., Meals on Wheels, home help				
Transportation services				
Other (Specify)				

(A = Adequate L = Limited I = Inadequate)

Based on the JPC's evaluation of this Section ( ), selected programs for the aged within the hospital district appear to be:

a. Adequate ______ c. Inadequate ______

b. Coordinated ______ d. Uncoordinated ______

and priority for further study and action is:

a. High ______ b. Low ______

B. 18 Accident/Injury Prevention

Introductory Comments and Sources of Information

Accidental injury continues to be the most frequent cause of death between ages 1-35, and remains one of the ten most frequent causes of death in the higher age groups. For every person in a fatal accident there are many more who suffer a disabling injury. Among the most frequent cause of disabling or fatal injuries are: motor vehicle accidents, falls, poisonings, drownings, and firearms.

Injuries from motor vehicles are associated with poor judgment and reckless behavior of drivers, excessive use of alcohol, excessive speed, carelessness, and mechanical failure. Often injuries to individuals involved in accidents are incurred by unskilled attempts to render first-aid services and to transport the patient.

Extensive community education programs, increased safety engineering in automobile design and manufacture, the use of safety belts and crash helmets, the placement of crossing guards at intersections for school children, and continuing driver education are all measures which can be promoted by organized community efforts and which help to reduce the number of serious injuries and deaths.

Most communities have a number of agencies and organizations engaged in a variety of injury prevention activities. Accidental injuries in the home, on playgrounds, in industry, and on farms deserve special attention. Home accidents inflict the largest number of injuries.

The following agencies and organizations have recognized injury prevention programs: the Alberta Safety Council, police, fire departments, industries, the Department of Agriculture, all schools, the Local Health Services Division, of the A.S.S. & C.H., the Workers Compensation Board, and the Department of Advanced Education.

Analysis and Interpretation

1) Is there coordination of accident prevention activities within the community?

2) Are accident rates in the community higher than in comparable communities and/or higher than they could be with aggressive community-wide accident and injury prevention activities?

3) Does the St. John Ambulance Corps provide first aid training and services in the hospital district? Is a register kept of individuals within the hospital district who have had first aid training during the past three years?

4) Are there ongoing programs to identify special characteristics in the community which present unusual hazards and to take appropriate action to prevent injuries?

5) Have the various accident and injury prevention programs in operation in the hospital district been effective in community education and prevention (actual) of accidents and injuries?

6) Have certain locales, such as traffic intersections, been identified with usually high accident rates?

7) What agencies are conducting public education programs on accident or injury prevention?

B. 18 Accident/Injury Prevention

Local Situation

(a) Determine the extent of deaths due to accidents:

Cause of Death	Total Number	Rate		
		Hosp. Dis.	Alberta	Canada
Motor Vehicle Accidents				
Home Accidents				
Industrial Accidents				
Burns				
Falls				
Poisonings				
Drownings				
Firearms				
Other (Specify)				

(b) What is the trend in overall death rates from accidental causes over the past decade?

Increasing ______ Decreasing ______ Same ______

(c) Identify injury prevention programs in operation:

Program	Agency Providing Service (Codes)	Evaluation		
		A	L	I
Highway safety				
Vehicle Inspection				
Driver education				
Use of Seat Belts				
Use of Crash Helmets				
Driver Physical Examination				
Bicycle Education/special routes				
School Crossing Guards				
Accident Investigation (deaths)				
Recration Safety				
Water Safety				
Firearm Safety				
Industrial Safety				
Home Safety				
Farm Safety				
Fire Safety				
School Safety				
Coordination of Safety Programs				
Other				

Based on the JPC's evaluation of this Section (   ), community programs within the hospital district for injury prevention appear to be:

a. Adequate ______
c. Inadequate ______
b. Coordinated ______
d. Uncoordinated ______

B. 19 Accidental Poisoning

Introductory Comments and Sources of Information

Thousands of individuals are poisoned accidentally each year in Alberta. In 1973, 4641 poisonings (accidental and non-accidental) were reported, with 161 fatalities. The majority of deaths due to poisoning among adults occur as a result of deliberate ingestion (i.e. suicidal intent). Nearly half of the poisonings in 1973 occurred among pre-school children although death rarely resulted in this group. Children are most often poisoned by aspirins and common household substances, although, in recent years, aspirin poisoning has declined in the pre-school age group. The fact that a large number of poisonings among pre-schoolers involves cleaning and polishing agents indicates a need for more education regarding home safety measures. Temporary lack of vigilance over children often allows accidents to occur. The kitchen is the most dangerous place in the house, followed by the bedroom and bathroom.

In Alberta, the Alberta Poison Control Service, a division of A.S.S. & C.H., has responsibility for many aspects related to poison control. The APCS assists the medical profession and other health personnel in the handling of accidental and other poisonings. The APCS has put out a manual, the APCSM, which provides pertinent information about many aspects of poisoning, including its preventive and treatment aspects. This manual is distributed to all hospitals, G.P.s, and pharmacists.

There are poison treatment centers (usually in the emergency departments) in 120 active treatment hospitals in Alberta. Three Poison Control Information Centers exist in the Province -- two in Edmonton (in the University and Royal Alexandra Hospitals) and one in Calgary (in the Calgary General Hospital). These Centers are available 24 hours a day for consultation with physicians and nurses. Their phone numbers are given in the APCSM.

Information regarding all aspects of poisoning (eg. analysis of substances, prevention, educational programs, resources) may be obtained from the APCS of the A.S.S. & C.H. and from the three Poison Control Information Centers.

Analysis and Interpretation

1) Is there an educational program to reduce or prevent poisonings? a. general public information? b. in the schools? What special programs are carried out to reduce accidental poisoning among young children and among older people?

2) Does an identifiable poison control program exist which includes public education, prevention, technical information for physicians, emergency services, and epidemiological follow-up of accidental poisoning?

3) Are analyses routinely made to determine causes of accidental poisonings that occur so that educational and corrective programs can be developed to prevent further occurrences?

B. 19 Accidental Poisoning

Local Situation

(a) Identify services and programs in operation to combat accidental poisoning:

Services	Agencies Providing Services (Code)	Evaluation		
		A	L	I
Information to family				
Information to physician				
Education for prevention				
Emergency care				
Analysis of substance				
Follow-up service of cases aged 5 and under by P.H. Nurse				
Alberta Poison Control Service				
Coordination of services				
Other				

(A = Adequate   L = Limited   I = Inadequate)

(b) List locations and telephone numbers of poison control (or information) centers in the hospital district:

Based on the JPC's evaluation of this Section (   ), programs to prevent and control accidental poisonings appear to be:

a. Adequate ______   c. Inadequate ______

b. Coordinated ______   d. Uncoordinated ______

and priority for further study and action is

a. High ______   b. Low ______

B. 20 Occupational Health

Introductory Comments and Sources of Information

Occupational health programs should aim to promote and maintain the highest possible level of health among the gainfully employed upon whom the economic welfare of a community depends. To meet these objectives it is necessary:

(a) To identify and bring under control at the work place, all chemical, physical, mechanical, biological and psychosocial agents that are known to be, or suspected of being, hazardous.

(b) To ensure that the physical and mental demands imposed on people at work by their respective jobs, are properly matched with their individual anatomical, physiological and psychological capabilities, needs, and limitations.

(c) To provide effective measures to protect those who are especially vulnerable to adverse working conditions and also to raise their level of resistance.

(d) To discover and improve work situations that may contribute to the overall ill health of workers, in order to ensure that the burden of general illness in different occupational groups is not increased over the community level.

(e) To educate management and workers to fulfil their responsibilities relevant to health protection and promotion.

There are many provincial and federal acts which have an occupational health content, including a number of regulations which establish safety standards. However, effective accident prevention and promotion of occupational health can only be achieved when there is cooperation between labor and management. Some large industries already have good occupational health programs. Hospitals, however, frequently lack such programs. It is with the smaller industries and agriculture that the principle problem of occupational health lies at the present and in the foreseeable future.

A comprehensive assessment of the occupational health status of the hospital district involves consideration of certain population characteristics (percent of total population working, age structure), and an assessment of the following characteristics: causes and amount of absenteeism; number of workers exposed to hazard; number and type of personnel; availability of services and facilities.

The Occupational Health Services Consulting Services of the Occupational Health Services Division of Alberta Labour could provide the JPC with valuable assistance in assessing the occupational health status of the hospital district.

A comprehensive occupational health program should include the following: counselling; health education; accident prevention; records; administration; cooperation; treatment; environmental control; rehabilitation; supervision of health.

Analysis and Interpretation

1) What hospital health services exist for all its employees?

2) Do some of the hospitals provide an occupational health service to the industries in this hospital district? By the health unit? Has this been considered by the respective boards?

Introductory Comments and Sources of Information

Analysis and Interpretation (Cont.)

3) Do the hospitals and the health unit encourage their employees to receive training in the area of occupational health nursing? (Certificate courses are offered through the Grant McEwan College, Edmonton).

References:

Government of Alberta, "The Report of the Industrial Health and Safety Commission," Edmonton: The Queen's Printer, 1975. This report contains valuable suggestions for improving the status of the occupational health of Alberta's workforce.

World Health Organization, Technical Report - Series No. 535, Geneva, 1973.

B. 20 Occupational Health

Local Situation

(a) Identify health services and programs designed for adults at work: Identify the occupational health programs and services in the hospital district:

Program	Available		Agency responsible	Evaluation		
	yes	no		A	L	I
Migrant health						
Farm safety						
Pesticide						
Other (Specify)						

(b) Identify components of occupational health programs in operation in the hospital district, and to whom they are available: (Use supplementary sheets to detail)

Program	Available		Agency responsible	Evaluation		
	yes	no		A	L	I
Pre-placement Examination						
Periodic Health Exam.						
Emergency Medical Care						
First Aid						
Health Education						
Rehabilitation						
Supervision of Health						
Environmental Control						
Other (Specify)						

(c) Identify occupational hazards within the community and programs to control and prevent them:

Hazard	Problem*		Control Program Identification	Evaluation		
	Yes	No		A	L	I
Toxic Emissions						
Chemicals						
Infectious and other Biological Hazards						
Allergies						
Noise						
Dust						
Radioactivity						
Industrial Accidents						
Solvents						
Other (Specify)						

*Identify source(s) as appropriate.

Based on the JPC's evaluation of this Section (   ), occupational health programs appear to be:

a. Adequate ______
b. Coordinated ______
c. Inadequate ______
d. Uncoordinated ______

B. 21 Disaster Plans and Planning

Introductory Comments and Sources of Information

Although certain disasters (such as earthquakes and hurricanes) are unlikely to happen in Alberta, certain events can realistically be expected to occur. Such events include: public utilities failures; tornadoes; flood; fires in high-rise buildings; gas explosions and dangerous emissions; aircraft disasters; infectious disease epidemics; school bus accidents (of particular concern in rural areas); and water pollution. Communities should have emergency plans for disasters and hospitals especially must be prepared to handle large numbers of casualties.

In Alberta, the Alberta Disaster Services Agency A.D.S.) has a primary responsibility for disaster planning (its current address and phone number is found in the Edmonton AID Directory). The Emergency Health Services (EHS) Branch of A.S.S. & C.H. has a primary responsibility for mass casualty care; its mandate includes the "Development of a medical, nursing, public health readiness, through approved exercise plans for any emergency/disaster conditions." Other agencies and organizations, such as the Red Cross, fire departments, A.G.T., the Departments of Highways, Forestry, Agriculture, and Municipal Affairs are all involved in planning, coordinating, and providing services.

Under the Alberta Disaster Act of 1973, each local authority in Alberta must establish an emergency disaster agency, appoint a director, and develop plans to meet emergency/disaster situations. Hospitals, schools and similar groups need to develop and test plans for: a) handling disasters; b) the immediate survival aspects (e.g., the first two weeks of a nuclear war); c) the continued survival and recovery after a two-week period.

Plans for health services in disaster must be rehearsed, integrated into the total community disaster plan, and coordinated with such other services as housing, transportation, feeding and welfare services. It should be remembered that the key to mass casualty care is hospital emergency planning. Of the 123 active treatment hospitals in Alberta in 1975, 115 have written exercise plans.

The ADS and EHS provide ongoing training programs, educational materials and consultation to interested parties in the Province. There are twenty fully equipped emergency hospitals stored in strategic places in Alberta, which are readily transferred to any community should the need arise in a "dire" emergency.

Analysis and Interpretation

1) Does each local authority (municipality) have an emergency disaster plan?

2) Does each hospital have a written exercise plan for emergency/disaster?

3) Are the current plans for the communities within the hospital district workable? Which have been rehearsed?

B. 21 Disaster Plans and Planning

Local Situation

(a) Identify disaster control programs in the hospital district:

Program	Regularly Held		Agency Code	Evaluation		
	Yes	No		A	L	I
Alta. Disaster Service Training exercise						
Emergency Hospital						
Health mobilization						
Medical self-help						
Other (Specify)						

(b) Identify disaster planning activities and responsibilities:

Planning Activity	Agency Responsible (Code)	Evaluation		
		A	L	I
Medical care				
Public health				
Emergency hospital (packaged)				
Hospital emergency plan				
School disaster				
Housing displaced persons				
Mass feeding				
Emergency transportation				
Emergency communications				
Emergency utilities				
Coordination of planning				
Other				

(c) Are medical and non-medical aspects of disaster plans functionally coorindated into a community-wide operational plan? Yes ______ No ______

(d) Other comments:

Based on the JPC's evaluation of this Section (   ), plans and programs for health services in case of disaster appear to be:

a. Adequate ______ c. Inadequate ______

b. Coordinated ______ d. Uncoordinated ______

and priority for further study and action is:

a. High ______ b. Low ______

SECTION C

QUESTIONS ABOUT:

ENVIRONMENTAL COMMUNITY HEALTH SERVICES

C. 1 Water Supplies and System

Introductory Comments and Sources of Information

Municipal water systems are those that are publicly owned. Semi-public water supplies are privately owned but serve public buildings such as restaurants, gas stations, trailer parks, camps, etc. Private residential supplies are those which serve the domestic needs of households. Community water supply sources are usually ground water or surface supplies (rivers, lakes, reservoirs). Ground water is generally safe but its purity must be maintained during pumping, storage, and distribution. Surface supplies are always unsafe and require treatment.

The safety of water supplies is determined by the adequacy of all parts of the water system. The adequacy of the system is determined, in part, through laboratory quality tests which reflect the condition of the water at the time of examination. However, a community may not assume that a few satisfactory results assure a consistently safe water supply. For example, one can at times secure a satisfactory sample from an open top well which is susceptible to contamination at any time.

The Standards and Approvals Division of the Department of Environment must approve plans prior to the construction of water works in order to ensure that construction will meet safety protection standards. This regulation may avoid costly errors in planning. Supervision of construction by a consulting engineer will assure that the water system will function as planned. It is often impossible to assure direct supervision of private water supply provisions. In Alberta some supervision is established through certification or licensure of tradesmen in the water field, ie., well drillers, plumbers.

The operation of water works should be routinely supervised to assure that the system is properly operated on a continuous basis. The Province licenses and trains operating personnel. Routine and random sampling is conducted by the Pollution and Control Division of the Dept. of Environment, both of bacteriological content and quality. The Public Health Unit tests for bacteriological content only. Advice on water supply matters/questions may be obtained from the Standards and Approval Division, and from the Pollution of the Dept. of Environment.

Analysis and Interpretation

References: Department of Health and Welfare, Canadian Drinking Water Standards and Objectives, 1968. Queen's Printer, Ottawa. (Presently under review).

Alberta Department of Environment, Surface Water Quality Criteria. August, 1970. Available from the Department of Environment.(Presently under review).

Standards and Approvals Division, Department of Environment, Recommended Standards for Water Supply and Sewerage, January, 1973. (Presently under review).

C. 1 Water Supplies and Systems

Local Situation

(a) **Problems:**

1) Have all water supplies been adjudged safe? Yes _____ No ______
List those for which a "no" answer was given:

2) Is all water treatment equipment adequate in quality and capacity? Yes _____ No ______
List specific deficiencies noted:

3) Are the distribution systems adequate in quality and capacity? Yes _____ No ______
Describe deficiencies:

(b) **Water Quality:**

1) Do all supplies meet acceptable bacteriological standards, based on periodic tests? Yes _____ No ______
List exceptions:

2) Is the chemical quality of water supplies adjudged to be within satisfactory limits? Yes _____ No ______
Describe deficiencies:

Local Situation

(c) - Services - Determine availability of the following:

Service	Status*			Jurisdiction Code(s)**	Evaluation		
	Y	N	U		A	L	I
Plan Approval							
Construction Approval							
Operation Supervision							
Sampling (routine)							
Consultation Available							
Trained Operators							

(d) Determine the kinds of treatment provided for public and semi-public water supplies:

Treatment	Status*			Jurisdiction Code(s)**	Evaluation		
	Y	N	U		A	L	I
Aeration							
Testing for nitrites							
Chemical (corrosiveness)							
Chlorination							
Filtration							
Fluoridation							
Other							

*Y = Yes; N = No; U = Unknown.

**Enter jurisdiction codes for those supplies which are deficient (i.e., a "No" answer)

Based on the JPC's evaluation of this Section (   ), provisions for supplying safe, potable water appear to be:

a. Adequate ______ c. Inadequate ______

b. Coordinated ______ d. Uncoordinated ______

and priority for further study and action is:

a. High ______ b. Low ______

C. 2 Sewage Disposal or Treatment

Introductory Comments and Sources of Information

Sewage is that water which has been utilized purposely to carry man-made wastes from the point of production. Thus it includes all liquid waste from 1) homes: toilets, showers, sinks, laundry (normally called domestic sewage) and 2) industrial sources: the liquid wastes from business operations. Food processing and the like result largely in organic wastes. Other industries discharge wastes containing chemicals, oil, radioactive materials, etc.

As a general rule, the safety of domestic and organic wastes can be determined only by careful examination and laboratory analysis. Wastes which are "safe" in one circumstance could be dangerous in another, e.g. growing of shellfish, swimming, water skiing, etc.

Sewage must be either disposed of or treated. Disposal is defined as retaining the wastes at the point of production, the most common method being leaching into the ground where the waste is simply stored or is used by soil micro-organisms. Treatment is defined as processing the waste to reduce or eliminate it, subsequently discharging the waste to some type of waterway.

Sewage has two undesirable properties: 1) it often constitutes a health hazard through (a) direct contact or (b) contamination of water supplies, and 2) it often is an aesthetic nuisance, i.e., is objectionable to the senses.

Sewage disposal is the responsibility of either 1) the creator of the waste as an individual or 2) some agency which has been created to serve this function (i.e., a municipal corporation, or a public utility company). In urban areas, public operation is usually more efficient than private systems.

Analysis and Interpretation

1) Do hazardous conditions exist, such as the pollution of streams or discharge of sewage on the ground surface, due to inadequate disposal or treatment installations?

2) Do nuisance conditions exist due to inadequate disposal or treatment installations?

3) Are disposal systems constructed and operated so as to prevent future nuisances or hazards?

4) Are treatment systems constructed and operated so as to prevent future nuisances or hazards?

C. 2 Sewage Disposal or Treatment

Local Situation

(a) For each city, town, village, or hamlet within the hospital district, determine the following conditions:

	Status*			City, town, village or hamlet affected (list name and/or Code)	Evaluation		
Condition or Status	Y	N	U		A	L	I
1. Nuisance - Sewage on ground							
- Sewage in waterways							
2. Untreated Toxic Wastes							
3. Services - Construction supervision (government)							
- Plans review							
- Operational supervision (government)							
- Corrective program							
4. For Public Systems - System's ability to handle sewage & storm water							
- All sewage treated							
- Plans for expansion for future needs							

*Y = Yes; N = No; U = Unknown

Based on the JPC's evaluation of this Section (   ), provisions for sewage disposal and treatment in the Communities of the hospital district appear to be:

a. Adequate ______   c. Inadequate ______

b. Coordinated ______   d. Uncoordinated ______

C. 3 Solid Waste Disposal

Introductory Comments and Sources of Information

Solid wastes are all non-liquid or non-gaseous unwanted materials of man. They include such things as garbage, paper, ashes, tin cans, glass, old toys, dead trees, or trimmings, and worn-out shoes.

In most communities there are three stages in the disposal of wastes: 1) storage awaiting collection, 2) collection and transportation to a disposal site, 3) operation of a disposal facility.

Organisation for disposing of solid wastes takes many forms. All three phases may be the personal responsiblity of the producer of the wastes. This arrangement is customary only in sparsely populated areas. The more common mechanics in Alberta are the collection and disposal on a fee basis by private enterprise. The fees are paid via the municipal office. Potential problems are associated with each chain of the disposal mechanism. In storage and disposal health hazards may occur as the result of insect breeding and rodent harborage. These are potential nuisance problems associated with all three stages.

In Alberta, it is standard practice for household wastes to be stored in water-tight, covered containers (which may be plastic garbage bags), collected at least once weekly and disposed of in a satisfactory manner immediately. Transportation of such wastes should be in water-tight, covered vehicles. The Provincial Board of Health issues the regulations governing the requirements for refuse disposal systems and the construction of disposal sites. Detailed information concerning all aspects of refuse disposal systems may be obtained from the Provincial Board of Health, and the public health inspector of the Health Unit in the hospital district will also be able to provide pertinent information.

Analysis and Interpretation

The health inspector of the health unit will be the expert source of information regarding assessment of disposal systems.

1) Is the solid waste collected at least once weekly in the municipalities?

2) Do the citizens store their solid waste in a satisfactory manner? If not, what educational efforts have been made to improve the situation?

3) Do all disposal sites within the hospital district meet the requirements governing new disposal sites?

C. 3 Solid Waste Disposal

Local Situation

(a) Problems: Determine if problems or nuisances exist which are attributable to any of the following:

1) Storage of wastes awaiting collection? Yes ______ No ______

2) Collection--spillage during hauling? Yes ______ No ______

3) Disposal site nuisance? Yes ______ No ______

4) Incinerator air pollution? Yes ______ No ______

For any "yes" answer above, describe the problem and the jurisdictions affected:

(b) Services: Determine the adequacy of selected services designed to prevent waste disposal problems:

1) Adequate enforcement of rules for compliance? Yes ______ No ______

2) Planning for future disposal site (or incineration) needs? Yes ______ No ______

For any "no" answer, describe deficiencies and jurisdiction(s) affected:

Based on the JPC's evaluation of this Section ( ), provisions for garbage, refuse, and other solid waste disposal appear to be:

a. Adequate ______ c. Inadequate ______

b. Coordinated ______ d. Uncoordinated ______

C. 4 Nuisance Abatement

Introductory Comments and Sources of Information

Numerous environmental conditions exist that are often termed nuisances. Some of them can cause physical health problems, others are primarily offensive to the human senses. Problems can arise in abatement of such nuisances since people vary in what they find offensive. A dog's barking is music to some, noise to others. Societal belief has it that a condition offensive to the majority must be removed. What these conditions are is determined by regulations passed by various levels of government. In Alberta, the Regulations Respecting Nuisances and General Sanitation, of the Public Health Act, and nuisance by-laws passed by municipal authorities, determine what constitute "nuisances" which can legally be abated.

Under the provincial regulations of the Public Health Act, a "nuisance" is "any condition existing in any locality that is or may become injurious or dangerous to health, or that might hinder in any manner the prevention or suppression of disease". Local Boards of Health have authority regarding the enforcement of the Regulations, the enforcement being delegated to the public health inspectors and their staff.

The table on the opposite page lists some conditions often considered to be nuisances. What the "nuisances" are in the hospital district may be determined from the provincial regulations and the by-laws of the municipalities.

The Public Health Inspector of the Health Unit covering the hospital district can assist in the assessment of the nuisance situation in the hospital district, and can provide viewpoints regarding problems, actions required, planning, etc.

Examples of nuisance conditions presenting health problems are: those transmitted by insects, rodents, (malaria, encephalitis, etc.). Bee stings, other insect stings, and allergic reactions caused by pollen from noxious weeds cause discomfort and sometimes death.

Analysis and Interpretation

1) What are the "nuisance" by-laws of the municipalities in the hospital district?

2) Is grain dust from grain elevators a problem?

C. 4 Nuisance Abatement

Local Situation

(a) Problems: Identify nuisance problems having health implications and the jurisdictions affecting them:

Problem	Status*			Jurisdiction Code(s)**	Evaluation		
	Y	N	U		A	L	I
1. Animals Presence							
Noise							
Running at large							
2. Plants (noxious) Poison ivy or oak							
Ragweed							
Other (specify)							
3. Insects Flies							
Mosquitoes							
Ticks							
Other (specify)							
4. Noise Transportation							
Manufacturing							
Other (specify)							

*Y = Yes; N = No; U = Unknown

**For each "yes" answer under "status", identify jurisdictions (particular town, village, etc.)

(b) Services:

1) Are the existing legal restrictions adequate to prevent or abate nuisances? Yes ______ No ______

2) What agency(ies) is (are) responsible for enforcement?

Based on the JPC's evaluation of this Section (   ), nuisance abatement programs within the hospital district appear to be:

a. Adequate ______

b. Inadequate ______

c. Inadequate ______

d. Uncoordinated ______

and priority for further study and action is:

a. High ______

b. Low ______

C. 5 Food and Milk Sanitation

Introductory Comments and Sources of Information

Foods have the potential for causing ill health due to several conditions: they may be toxic or infective as produced (i.e., poisonous mushrooms, pork infected with trichina, milk from tuberculous cows), or they may become contaminated during processing, transportation, and storage, or during preparation or serving.

The pattern of food production and distrubution is such that a local community could not maintain complete surveillance over the production, processing and handling of its food supplies. Federal and provincial regulations and standards are therefore necessary to ensure that the quality of food and milk does not contribute to ill-health. The Alberta Provincial Board of Health issues regulations governing the standards of care to be maintained in the handling of foods and milk, as well as many other aspects of the food industry (e.g. food storage, preparation and serving of food in public eating places, etc.).

Food safety may be approached from the standpoint of: 1) illnesses caused by food and 2) the existence of conditions or practices which carry a risk of food-borne illness. Usually, the Health Unit will have information concerning food-borne illness contracted in public eating places, or from a common food source. General practitioners will be more aware of illness resulting from food-handling practices in the home.

The Health Unit's public health inspector will be the expert source of information regarding the local situation with respect to food and milk sanitation in the hospital district, and will be able to identify current problems and improvements. Provincial regulations regarding food and health regulations, restaurants, fluid milk standards, etc., may be obtained from the Provincial Board of Health, Edmonton, or from the Health Unit.

Analysis and Interpretation

C. 5 Food and Milk Sanitation

Local Situation

(a) Problems: Identify presence of selected food and milk sanitation problems and sources:

Problem	Status*			Location of Problem	Evaluation		
	Y	N	U		A	L	I
1. Food-Borne Illness - Public eating places							
- Private homes							
2. Unsafe conditions and practices - Food from other areas							
- Locally produced foods							
- Wholesale storage							
- Retail outlets							
- Preparation/Serving							

*Y = Yes; N = No; U = Unknown

(b) Services: Identify selected food protection services:

Service	Status*			Jurisdiction(s) Affected**	Evaluation		
	Y	N	U		A	L	I
Program re Food Wholesomeness							
Monitoring Food Storage/ Distribution							
Monitoring Public Eating Places							
Education re Home Practices							

*Y = Yes; N = No; U = Unknown

**Identify those jurisdictions which are deficient (i.e., a "no" answer)

Based on the JPC's evaluation of this Section (   ), food and milk sanitation programs within the hospital district appear to be:

a. Adequate ______
c. Inadequate ______
b. Coordinated ______
d. Uncoordinated ______

and priority for further study and action is:

a. High ______
b. Low ______

C. 6 Swimming Pools and Bathing Areas

Introductory Comments and Sources of Information

There are special health and safety considerations connected with swimming areas, whether artificial pools or natural areas(such as quarries, rivers, and lake beaches). Organized swimming areas should have adequate and convenient drinking and waste disposal facilities.

Swimming pools should maintain clear water of chemical quality which does not irritate the skin or eyes of the bathers. Public swimming pools must in all cases be filtered and disinfected to prevent transmission of disease, and have available life guards and safety equipment. It is normally impossible to disinfect water in natural bathing areas. Such areas should be restricted to those where safe qaulity of water is available. It is important that community members be made aware of any areas where water quality is such that swimming is a significant health hazard.

In Alberta there are a number of government departments having a primary responsibility in the area of water control and safety of swimming pool and bathing areas. The Public Health Units of the Local Board of Health Division of the A.S.S. & C.H. monitor the water safety and quality of man-made beaches and dug-outs. All such bathing areas must have a permit from the Public Health Unit. The Public Health Unit also has responsibility for the water quality control of private swimming pools.

The Standards and Approvals Division of the Department of Environment establishes the requirements for, and makes recommendations about, the construction of swimming pools. (See References)

References:

Alberta Department of Environment, Recommended Swimming and Pool Design and Operating Standards, January, 1973. (Available from the Department)

Alberta Department of Environment, Swimming Pool Operator's Manual. (Available from the Department).

Analysis and Interpretation

1) How many public natural bathing areas (lakes, rivers, etc.) are there in the hospital district?

2) How many public swimming pools are there?

3) Are all natural bathing areas free from sewage or other pollutants?

4) How frequently are surveys made of the public bathing areas? What were the results of the most recent reports? For those which were unsatisfactory, explain the deficiencies.

5) Are daily operating records maintained at all public bathing places and swimming pools?

6) Are there any high-risk areas in which physical safety hazards constitute a problem needing attention?

C. 6 Swimming Pools and Bathing Areas

Local Situation

(a) Identify facilities and conditions in pools and bathing areas, noting deficiencies which exist and jurisdictional location:

Facility	Status*			Jurisdiction(s) Affected **	Evaluation		
	Y	N	U		A	L	I
Drinking water							
Toilet facilities							
Garbage facilities							
Life-guards							
Safety equipment							
Water quality - Chemically safe							
- Bacterially safe							

*Y = Yes; No = No; U = Unknown

**Identify jurisdictions in which deficiencies exist, i.e., a "no" answer.

(b) Have construction standards been followed for construction of bathing facilities in all areas of the hospital district?

Based on the JPC's evaluation of this Section (   ), measures to assure health and safety in swimming pools and bathing areas in the hospital district appear to be:

a. Adequate ______ c. Inadequate ______

b. Coordinated ______ d. Uncoordinated ______

and priority for further study and action is:

a. High ______ b. Low ______

C. 7 Institutional Health and Safety

Introductory Comments and Sources of Information

Various types of institutions, both public and private, exist in any community. They include educational facilities (e.g. nursery, day care center, schools, colleges), health facilities (eg. hospitals, nursing homes, mental care facilities) and custodial facilities (e.g. rest homes, homes for the aged, penal institutions). Congregation of large numbers of people for varying lengths of time is a factor common to all.

Certain environmental conditions have been previously covered in the ACHSSO (i.e., water supply, waste disposal, food safety). In institutions, factors having environmental significance are: heating, lighting, safety, plumbing, ventilation, fire hazards, laundry, space, bathing facilities, general housekeeping practices, etc.

In Alberta, several public agencies have responsibility for conditions in institutions and will have information on environmental conditions Administrators of the various institutions within the hospital district are often the knowledgeable local sources of information about regulations governing institutions. Personnel from the Homes and Institutions Branch of the A.S.S& C.H. are other knowledgeable sources. This branch also provides information about regulations for the building and operating of various kinds of institutions.

Environmental factors of concern in various institutions have been covered in previous pages. It may be that other study groups have identified problems in institutions during their attention to such subjects as water supply, waste disposal, food safety, and other environmental areas.

Analysis and Interpretation

1) Is there an adequately functioning program for ensuring that health and safety standards are maintained in institutions?

2) Are present provisions for periodic inspection, supervision, monitoring, evaluation, and consultation on sanitation aspects of institutions adequate?

C. 7 Institutional Health and Safety

Local Situation

(a) **Problems:** Identify health and safety problems which may exist in the following types of institutions:

Institutions	Problems			Types of Problems	Evaluation		
	Y	N	U		A	L	I
Schools - Public							
- Private							
Hospitals							
Nursing Homes							
Senior Citizens Lodges							
Penal Institutions							
Public Buildings							
Child Care Facilities							
Other							

(A = Adequate L = Limited I = Inadequate)
Y = Yes; N = No; U = Unknown

(b) What agency(ies) is(are) responsible for insuring the health and safety conditions of institutions?

Based on the JPC's evaluation of this Section ( ), programs for institutional health and safety appear to be:

a. Adequate ______
c. Inadequate ______
b. Coordinated ______
d. Uncoordinated ______

and priority for further study and action is:

a. High ______
b. Low ______

C. 8 Air Pollution

Introductory Comments and Sources of Information

Air pollution means the presence of air contaminants in sufficient concentration to cause harm. The harm may range from damage to property and disruption of services, to injury to vegetation, animal, or human life. The major man-made air contaminants fall into two broad classes: 1) gases, 2) particulates (or particles both solid and liquid). The major gas pollutants are the sulphur oxides, carbon monoxide, the nitrogen oxides and hydrocarbons.

Air pollution is everyone's responsibility--individuals, industry, and public agencies. The public in Alberta fortunately has had little experience with the discomfort produced by eye and nose irritation, particle fallout, low visibility, and damage to crops and corrosive action to structures. It is difficult to assess the extent to which the public is aware of the actual or potential long-range cumulative effects of air pollution on health.

The principal sources of air pollution are the smoke stacks of industry, institutions, and private dwellings, community refuse dumps, individual backyard incinerators, and automobile and truck exhaust.

Control activities involve the total community effort. Much can be accomplished at the local level as for example, control of backyard burning and other smoke control regulations. The value of this might be limited if a neighbouring community does not have similar control measures. Experience in other parts of Canada has demonstrated the desirability of meeting the air pollution problem on a regional basis. In Edmonton and Calgary, the Department of Environment operates an "Ambient Air Monitoring Network" around the clock. In other parts of the Province it operates rover trailers with monitoring equipment which are used to inspect the emission of sulphur dioxide by gas industry plants. The latter service is operated by the Department of Environment's "Sour Gas Plant Network".

Though many specific health effects of air pollution still have not been isolated, there is little question that in acute situations, increasing numbers of deaths have occurred among those with chronic respiratory and cardiovascular conditions, and among the aged.

Analysis and Interpretation

Community air pollution may be assessed in terms of 1) sources and 2) effects. Are adequate air pollution programs functioning which serve to prevent or eliminate air pollution problems and which incorporate (a) monitoring for pollutants, (b) analysis of pollutants, (c) adequate legal support and provision for enforcement of regulations to prevent or eliminate air pollution?

References:

Fisher, J., What You Can Do About Pollution Now. Toronto: Longman, 1971.

Chant, D.K., Pollution Probe, Toronto: New Press, 1970.

C. 8 Air Pollution

Local Situation

(a) Problems: Identify existence of problems of air pollution, sources and location where possible:

Problem	Status*			Source (and location)	Evaluation		
	Y**	N	U		A	L	I
Vegetation/crop damage							
Eye/nose irritation							
Particle fallout							
Reduced visibility							
Noises							
Odors							
Other							

(A = Adequate L = Limited I = Inadequate)
*Y = Yes; N = No; U = Unknown
**If yes, note whether it is a major, minor, moderate, or frequent problem, using the abbreviations: Ma = Major; Mi = Minor, Mo = Moderate; Fr = Frequently.

(b) Services:

1) What regulations and laws exist for controlling air pollution in the hospital district?

2) Name the agencies responsible for enforcement of the above laws and regulations:

Based on the JPC's evaluation of this Section ( ), air pollution control efforts appear to be:

a. Adequate ______ c. Inadequate ______

b. Coordinated ______ d. Uncoordinated ______

and priority for further study and action is:

a. High ______ b. Low ______